HIERARCHIES OF RISK:
THE LONGITUDINAL DYNAMICS OF FAMILY, WORK, WELFARE, AND HEALTH INSURANCE IN LOW-INCOME WOMEN'S LIVES

BY

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ABSTRACT

Low-income women are at particularly high risk of having no or inadequate insurance. Welfare reform has pushed more low-income women into the labor market but women's access to insurance has continued to erode. In addition, low-income women often experience work and family changes which affect their ability to access both private/employer-based and public insurance programs. We know continuity of coverage matters for women's health, but few have examined the role of individual-level health insurance instability in perpetuating low-income women's poverty. Cross-sectional analyses do not adequately reflect the dynamic nature of low-income women's lives and their lack of continuity in health insurance access.

The goal of this dissertation is to assess the role of individual-level welfare, work, and family changes in predicting low-income women's access to insurance and poverty over time in order to inform effective social policy. Specifically, I seek to answer the following research questions: 1) What is the relative importance of various welfare, work, and family changes in predicting low-income women's insurance coverage over time? 2) Given the diversity of low-income women's experiences, are there significant differences between categories of low-income women (such as the poor and near-poor) in the significance of these changes and women's access to insurance? And 3) given the effects of welfare, work, and family changes on low-income women's health insurance access, what role does health insurance stability play in determining changes in women's poverty status over time?

Results of the various statistical analyses provide consistent evidence of a hierarchy of risk among low-income women. For example, I find that low-income women who experience welfare, work, and family changes may have access to public and private forms of insurance, but compared to women with stable welfare, work, and family attachments low-income women who

experience many changes over time simply do not fare as well and are at greater risk of being uninsured or having unmet health needs. I also find evidence that the significance of various welfare, work, and family factors varies by type of insurance examined. For instance, while stable marriage and work patterns may increase women's access to private forms of insurance while reducing their access to public forms of insurance, the same factors do not significantly predict women's risk of being uninsured. Nevertheless, this should not suggest that marriage and work patterns are unrelated to women's risk of being uninsured. Instead, I argue that such findings illustrate the complex effects of welfare, work, and family factors on women's access to various forms of health insurance; while some low-income women may benefit from access to marriage and work opportunities, others may find themselves at greater risk of lacking access to sufficient insurance. The complex and contradictory nature of these effects may make them difficult to model statistically but illustrate the importance of examining the nuances of low-income women's lives.

I also find evidence that certain factors may be more (or less) consequential for poor women than their near-poor peers. Such findings provide evidence of the differential strategies low-income women utilize in order to meet their health insurance needs – poor women's reliance on public forms of health insurance creates different risks for them than their near-poor peers who are forced to rely on private forms of insurance to meet their health needs. Finally, I find some limited evidence that certain welfare, work, and family factors are indeed related to low-income women's movement into and out of poverty over time. I conclude by arguing that recent health care reforms have the potential to significantly improve low-income women's access to insurance, thereby altering the hierarchy of risks many low-income women face under the status quo.

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CHAPTER ONE

INTRODUCTION

Insurance Instability in America

In 2008 over 45.7 million Americans under the age of 65 (17.4 percent of the United States' nonelderly population) had no health insurance coverage (Holahan and Cook 2009) and as many as 25 million more adults were underinsured, meaning they had access to insurance but it was insufficient to meet their needs or consumed a significant proportion of their income (Schoen et al. 2008:298; Raiz 2006; Schoen et al. 2005). Research shows a great deal of turnover among the uninsured, with very few people remaining continuously uninsured for extended periods of time (Short and Graefe 2003). High rates of insurance instability suggest that cross-sectional statistics may severely underestimate the risk of being uninsured in America, underscoring the need to examine continuity in coverage over time (Schoen and DesRoches 2000).

In the U.S. two-thirds of the uninsured live in low-income families (Hoffman et al. 2008:4). This includes approximately 8.5 million uninsured low-income women, who comprise 19 percent of the uninsured population (Wyn et al. 2001:14). Despite their high labor force participation rates, low-income women are three times more likely to be uninsured than near-poor women (Wyn et al. 2001:14) and two to three times more likely to face insurance instability (Anderson and Eamon 2004:397). Even as public health insurance programs have been expanding to catch those left behind by welfare reform, the rate of low-income women's health insurance coverage has been falling (Glied, Jack, and Rachlin 2008; Kaiser Family Foundation

2008a; Wyn et al. 2001:52). With the cost of health care rising, more and more women are reporting difficulties accessing care due to cost (Patchias and Waxman 2007).

Accurately understanding low-income women's access to health insurance requires understanding health care as a central component of welfare regimes. According to welfare state scholars, social inequalities in postindustrial societies are shaped by the relationship between the labor market, state, and family (DiPrete et al 1997; Esping-Andersen 1990, 1999; O'Connor et al. 1999). Although universal health care is a central component of many industrialized welfare states, health insurance is merely a residual feature of the U.S. welfare regime (Hacker 2002; Quadagno 2004, 2005). The structure of the U.S. health insurance system relies primarily on employer-provided insurance schemes, which assume stable attachment to the labor market or a spouse, and categorical public health insurance programs designed to meet the needs of select categories of women (Iglehart 2007; Kaiser 2007). These programs have been developed with the traditional breadwinner/homemaker family model in mind. Because marriage/family, employment, and social policy characteristics shape low-income women's needs for and access to both private/employment-based and public insurance, if we are to accurately understand low-income women's access to health insurance, we must examine their lives in the context of this state-market-family relationship.

Current economic conditions are predicted to result in further erosion of employer-provided benefits and greater demand for public sources of health insurance over the next decade (Dorn et al. 2008; Holahan and Cook 2008b). For every one percent increase in unemployment, we can expect 1.1 million more adults to become uninsured (Dorn et al. 2008). As the unemployment rate nears 10 percent, estimates suggest that we may see as many as 51 million uninsured (Holahan and Garrett 2009:6; Holahan and Cook 2008a; Schwartz 2008). Long-term

projections estimate close to 67 million uninsured by 2018 unless significant policy changes are implemented (Burman et al. 2008:56). Although some scholars predicted that a severe enough economic recession could serve as an "external traumatic event" significant enough to ignite greater support for expanding health insurance access in the U.S. (Enthoven and Fuchs 2006), few could have predicted how the divisive political climate would split public and congressional support for major health care reform in 2009-2010 (see Kaiser Family Foundation 2010a). The passage of the Patient Protection and Affordability Act and Health Care and Education Reconciliation Act in March 2010 is notable given the United States' history of failed health care reform efforts; during the 20th Century there were six substantial efforts to mobilize support for expanding health insurance in the U.S., none of which resulted in universally expanded health insurance access (Hoffman 2003; Kahn and Pollack 2001; Starr 1982). Despite the significance of the 2010 health care reform law, the U.S. has yet to follow its European peers in establishing a comprehensive national health insurance system (Quadagno 2004).

Low-income Women's Access to Health Insurance

A fragmented health insurance system that relies on the combination of employer-based benefits and residual public programs creates substantial barriers to obtaining adequate health insurance for low-income women (Glied, Jack, and Rachlin 2008; Pearlman 1998). Medicaid has primarily been designed to meet the needs of pregnant women, children, and the disabled, restricting access to public health insurance for many women (Iglehart 2007; Kaiser 2007). Although seven in ten adults on Medicaid are low-income women, less than one-quarter of all low-income women actually qualify for Medicaid due to the program's strict income-eligibility guidelines (Wyn et al. 2001:2, 14). In fact, one study finds that a mother of a family of three

working full-time at minimum wage would not qualify for Medicaid in 29 states in 2007 based on her income (Hoffman et al. 2008:19). Medicaid's strict categorical and income requirements are particularly consequential for the thousands of low-income women who have been forced into low-wage jobs following welfare reform (Cheng 2007; Seccombe, Newsom, and Hoffman 2006). Ironically, although the wages of low-income women are often insufficient to meet the needs of their families, in many cases they are significant enough to disqualify them from programs like Medicaid.

Low-income workers are more likely to be uninsured since they are less likely to be offered job-based coverage and are less able to afford the cost of premiums (Kaiser Family Foundation 2008b). The employment patterns of low-income women in particular put them at significantly greater risk of falling into the cracks left by a patchwork of public and private health insurance schemes (Wyn et al. 2001). Fifty-eight percent of low-income women are employed and 72 percent live in working families (Wyn et al. 2001:48). Two-thirds of employed low-income women work in service, administrative support, or sales occupations (Wyn et al. 2001:53). Despite their high employment rate, low-income women are two times less likely to have job-based health insurance than near-poor women across every occupation category (Wyn et al. 2001:25, 54). Whether employed full or part-time, year-round or seasonally, about one-third of low-income working women are uninsured (Wyn et al. 2001:51). Job changes and/or job loss are one of the biggest reasons for a lack of insurance among the uninsured (Hoffman et al. 2008), and low-income women's job instability puts them at significantly greater risk of insurance instability than higher income women (Anderson and Eamon 2004:400).

Family structure influences health insurance coverage by providing access to resources and the ability to access benefits as a dependent (Institute of Medicine 2002). Overall, women

are more than twice as likely as men to get access to employer-based insurance through a spouse (Wyn et al. 2001: 23), but their coverage is contingent on the stability of their relationships, the continuity of men's employment, and the willingness of employers to continue offering family benefits, making dependent coverage a much less stable form of insurance for women (Patchias and Waxman 2007). Although many low-income women want to marry, they are often unwilling to assume the risk of dependency to economically unstable men, which contributes to the relationship instability of low-income couples (Edin and Kefalas 2005; Rogers-Dillon and Haney 2005). One consequence is that low-income women are less likely to be married and stay married than near-poor women, and thus, significantly less likely to get insurance through a spouse (Anderson and Eamon 2004:399). In spite of their labor force participation, only 27 percent of low-income single moms are able to secure benefits through their employment, resulting in Medicaid being a significant source of insurance for 39 percent of low-income single moms (Wyn et al. 2001:23).

Not having insurance or having inadequate coverage creates barriers to regular health care (Kaiser Family Foundation 2008b; Raiz 2006). Because low-income families are more likely to have no financial reserves to cover the cost of an unexpected medical need, they are significantly more likely to delay or forgo needed care (Hoffman et al. 2008; Vuckovic 2000). Even temporary gaps in coverage put one at greater risk of poor health by preventing both access to preventative care and early detection of illness (Marquis and Kapur 2003). Lack of access to adequate health insurance and resultant poor health affects worker productivity and results in employment disruption (Institute of Medicine 2003). Ultimately, the un- and underinsured are at greater risk of medical debt, bankruptcy, and even poverty (Collins et al. 2008a; Hoffman et al.

2001, 2008; Institute of Medicine 2004; Kaiser Family Foundation 2008b). These risks pose substantial barriers to low-income women's economic progress.

The Need for Further Research

Despite a plethora of research on health insurance access among the poor in the U.S., much remains to be understood about the role of health insurance stability in the lives low-income women. For example, we know that the uninsured population experiences a great deal of turnover over time (Short and Graefe 2003) and that continuity of insurance coverage matters for maintaining health (Marquis and Kapur; Schoen and DesRoches 2000). Yet relatively little attention has been paid to understanding the *individual-level* changes that make low-income women particularly vulnerable to insurance instability, or *variability* in the effects of these changes among categories of low-income women, or the role of these factors in either fostering or preventing low-income women's movement out of *poverty*.

Researchers certainly recognize the importance of examining change. For instance, Glied, Jack, and Rachlin (2008) provide an important analysis of the effects of demographic transitions on rates of women's insurance coverage, finding evidence that family, work and policy changes have significantly impacted the distribution of women's health insurance in the US. But they do not examine the relationship between *individual-level* changes in family, work, and public program access and individual women's insurance instability. Scholars also recognize the importance of examining variability. For example, Anderson and Eamon (2004) examine differences in insurance instability among working women and find that low-income women are particularly vulnerable to gaps in coverage compared to near-poor women. Nevertheless, we know from the work of scholars such as Edin and Lein (1997) that within the low-income

population there is a great deal of variability in the work, family, and welfare opportunities these women have access to. Finally, social scientists have certainly been concerned about poverty. For instance, using Census data, DeNavas-Walt, Proctor, and Smith (2008) document in striking detail how the poor are disproportionally represented among the un- and underinsured. Yet little research has adequately attempted to assess how the instability of low-income women's lives creates barriers to both their ability to be stably insured and their opportunities for socio-economic advancement.

Research Objectives

The primary objective of this dissertation is to assess the role of individual-level welfare[2], work, and family changes in predicting low-income women's insurance instability over time in order to determine the role of insurance instability as a barrier to low-income women's economic progress. Adequately measuring change necessitates the use of longitudinal data and analytic techniques. In addition, understanding the relationship between individual-level changes and insurance access also requires determining variability in the effects of these forces among different groups of low-income women – although we often treat low-income women (those with household incomes less than 200 percent of the Federal Poverty Level) as a homogenous category, welfare, work, family, and insurance changes may be more consequential for poor women (those with household incomes less than 100 percent of the Federal Poverty Level) given their more severe economic vulnerability.

[2] Although I use the term "welfare" throughout this dissertation, it is important to make the distinction between "welfare assistance" and the "welfare state". While the welfare state encompasses a wide range of social policies intended to sustain the citizens of a nation (see scholars such as Esping-Andersen 1990; 1999, among others), often the term "welfare" is used in public discourse as short-hand to describe cash assistance for the poor. When I use the term "welfare" in this dissertation I am referring to utilization of the program TANF (Temporary Aid for Needy Families); when discussing the "welfare state" I try to make clear that I am referencing a much larger set of social policies beyond targeted cash assistance for the poor.

The second objective of this dissertation is to utilize the results to help inform social policy. Reliance on an employment-based insurance system to meet the needs of most Americans has resulted in substantial disparities in health insurance coverage and health care access across race, class, and gender lines (Raiz 2006). How we organize, finance, and provide health care services has important gender and race implications (Zimmerman and Hill 1999, 2000). Lack of access to adequate and affordable health care is an enduring source and consequence of social inequalities in the U.S. (Kawachi and Kennedy 2002; Wilkinson 2006). As health care costs continue to climb, the gap between the insured and uninsured in access to care is widening (Hoffman and Schwartz 2008). We know that marriage promotion policies have not worked to elevate low-income women out of poverty (Edin and Kefalas 2005; Rogers-Dillon and Haney 2005) and welfare-to-work policies have simply transferred welfare-reliant women into the ranks of the wage-reliant without substantially altering their well-being (Edin and Lein 1997; Hays 2003). But if it can be shown that lack of access to stable insurance poses a significant barrier to low-income women's economic progress, then providing universal and comprehensive health insurance access would be a critical component of any effective policy solution to low-income women's poverty. Understanding the relative importance of welfare, family, and employment changes in contributing to low-income women's health insurance stability, the relationship between health insurance stability and low-income women's poverty, and possible differences in the effects of these factors between poor and near-poor women would provide justification for significant health care reform and would also allow us to develop better policies to meet the needs of low-income women.

Outline of Subsequent Chapters

In Chapter Two I review relevant literature related to my research questions, including the effects of welfare reform, employment instability, and marriage and family changes on women's ability to secure health insurance, as well as important race/ethnic variations in insurance access. I also describe the usefulness of a feminist welfare regime perspective for guiding and interpreting analyses of low-income women's access to health insurance. This chapter also provides further justification for this dissertation, including the limitations of previous research and the need for considering work, welfare, and family sources of instability when examining low-income women's insurance instability. I conclude this chapter by outlining the major research questions that guide this study as well as hypotheses about the relationships between the major variables identified.

Chapter Three describes the data and methods utilized in this dissertation, including the appropriateness of the data set, sampling procedures, and variable descriptions. This chapter contains an explanation of the statistical methods used to examine the data, my analytic plan, and model summaries. This chapter also includes a summary of descriptive statistics.

In Chapters Four, Five, and Six, I test each of my major research questions using different measures of women's welfare, work, family, and health insurance variables. Chapter Four describes the results of a series of *lagged effects* analyses which examine the long-term effects of Time 1 welfare, work, family, and health insurance statuses on women's health insurance and poverty statuses at Time 2. Chapter Five contains the results of a series of analyses which utilize measures of women's welfare, work, family, and health insurance *changes* over time in order to predict women's access to various forms of insurance and poverty status at Time 2. Chapter Six provides the results of a series of analyses testing how women's welfare, work, family, and health insurance *trajectories* affect women's access to various forms of health

insurance and poverty status over time. One of the major differences between Chapters Five and Six is that in Chapter Five I measure changes across two time points, whereas in Chapter Six I measure changes across three time points.

Finally, Chapter Seven provides a discussion of the study results, including their implications for social theory and policy, an explanation of the study limitations, and directions for future research. In this chapter I also explore how the recent passage of health care reform legislation might impact the lives of low-income women like those examined in this dissertation.

CHAPTER TWO

LITERATURE REVIEW

Welfare Regimes

In order to examine the relationship between individual-level change, health insurance instability, and poverty among low-income women, I use a welfare regime perspective. Welfare regime scholars argue that adequately understanding the relationship between the post-industrial welfare state and social inequalities requires situating analyses within the context of the state-market-family nexus (Esping-Andersen 1990, 1999; Hacker 2002; O'Connor, Orloff, and Shaver 1999). Although many health insurance scholars utilize employment, family, social policy, and race/ethnicity variables in their analyses, very few interpret their results using a feminist welfare regime framework. As opposed to treating state, market, and family institutions as separate forces with independent effects, a feminist welfare regime approach considers the complex relationships *between* state, market, and family forces, the *racialized* and *gendered* nature of these institutions, and the effects of entire *welfare regimes* on low-income women's lives.

The concept welfare regime was made popular by Esping-Andersen (1990, 1999) who used the term to describe the broad complex of state and economic policies which constitute the welfare state. The utility of this concept was in its call to think about the welfare state in terms beyond simple welfare benefits. Instead, Esping-Andersen asked that we also consider the institutional arrangements and rules that shape policy decisions, program definitions, and "even the response and demand structure of citizens and welfare consumers" (Esping-Andersen 1990:80). Esping-Andersen's analysis drew attention to decommodification (one's ability to

exist outside of formal attachment to the labor market) and the dynamic relationship between the state and the economy, illustrating how changes in one institution created changes in the other.

Although Esping-Anderson's welfare regime typology provided a useful theoretical starting point for many scholars, feminists have criticized his schema for not taking gender seriously (Hobson 1991; Orloff 1993, 1996: Fraser 1994; Sainsbury 1996, 1999; O'Connor, Orloff, and Shaver 1999; Goodin et al. 1999; Korpi 2000). Feminists were particularly critical of his implicit assumption of the citizen as male worker, his neglect of women's unpaid labor, and his underdevelopment of the family dimension of welfare regimes. In response, Orloff (1993) called for a gendered conceptualization of Esping-Andersen's decommodification that would better consider gender inequalities in access to paid work and women's capacity to form and maintain an autonomous household. Sainsbury (1996) similarly called for analyses of welfare regimes' support for defamilialization, or the ability to thrive outside of traditional family relationships.

Feminist welfare state scholars recognize that the U.S. welfare regime is not a uniform structure, but a network of competing institutions composed of multiple gender arrangements shaping recognition and redistribution (Haney 1996, 2000). One of the important contributions they make is drawing attention to the role of social policies in shaping social inequalities produced through families and markets (Chow and Berheide 1994; Christopher et al. 2002; DiPrete and McManus 2000; Folbre 1984). In particular, their work highlights the significance of the traditional, gendered, nuclear family wage scenario in shaping the structure of the post-industrial labor market and welfare state (Fraser 1994; Gordon 1994). Their work also illustrates how inequality is not "natural" but the result of social policies that foster disparities (Fischer et al. 1996; Hernes 1987; Pascall 1986).

Although the gendered nature of the welfare state has been established, some argue that state narratives have only recently considered national politics of race and ethnicity (Glenn 2002; Lewis 2000; Williams 1995). Contemporary scholars now more readily acknowledge that race is embedded in state policies (Gilens 1999; MacKinnnon 1998; Naples 1998), particularly through systematic exclusion of minority and immigrant populations from access to "legitimate" social benefits (Glenn 2002; Quadagno 2000). Their work shows how the effects of social policies vary dramatically by race and gender, perpetuating inequalities in poverty (Bashevkin 2002; Moller 2002), and resulting in the overrepresentation of minorities and women in residual, means-tested social programs (Quadagno 2000). Further reinforcing race and gender inequalities, welfare discourses utilize images such as the "underclass" to imply blackness and sexual impropriety, which creates hostility toward program recipients (Neubeck and Cazenave 2001) and fosters a lack of wide-spread public support of social programs (Gans 1995; O'Connor 2000; Whitaker 2002).

Because healthcare in the U.S. is provided primarily through the private market, few welfare state scholars have examined health insurance as they have other components of welfare regimes - such as mother's pensions (e.g., Cauthen and Amenta 1996) or poverty reduction programs (e.g., Korpi and Palme 1998). But the U.S. system of private benefits relies heavily on public subsidies, making it a critical component of the welfare state (Hacker 2002). Thus, I argue that a welfare regime perspective provides an appropriate and useful framework for understanding the complex relationship between macro-level state and market forces, meso-level family factors, and individual-level welfare, work, and family changes that shape low-income women's access to health insurance and perpetuate race, class, and gender inequalities in health and economic well-being.

Welfare Reform

Neoliberal economic restructuring and welfare state retrenchment have resulted in substantial cuts in public benefits both globally and nationally (Harvey 2005; Korpi 2003; Myles and Quadagno 2002). But because retrenchment is politically risky, these reforms have been carried out using subtle discourses that obscure cuts by blaming budget deficits, the impending crisis of the aging baby boomers, and the effects of global competition (Quadagno 1999; Schram 2000). These changes, combined with the erosion of wages, loss of manufacturing jobs, and cutbacks in social programs such as food stamps and housing supports, have had particularly important impacts on the lives of low-income women who have suffered most from the further feminization of poverty (Mittelstadt 2005).

One of the most consequential neoliberal reforms for low-income women in the U.S. was the 1996 Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) which replaced Aid to Families with Dependent Children (AFDC) with Temporary Aid for Needy Families (TANF). TANF ended cash benefits for the poor, limited lifetime benefits to five years, and required workfare (participation in paid employment) for public assistance (Abromovitz 1996 [1988]; Trattner 1999). In effect, this reform removed support for low-income women's unpaid care giving and entitlements based on social rights (Myles and Quadagno 2002). In an effort to encourage workforce participation the Earned Income Tax Credit (EITC) was expanded. In fact, for many low-income women EITC credits are now larger than direct cash assistance benefits, making it an important source of supplementary income for low-income women (Cherlin and Fomby 2004). Despite the expansion of EITC, because the work requirements and incentives introduced with welfare reform were not accompanied by guaranteed employment

opportunities (Schram 2000), the ultimate result has been the expansion of the working poor (O'Connor 2000).

Welfare reform was intended to curb low-income women's access to cash benefits and encourage their labor force participation, but these policy changes also had the consequence of affecting their access to health insurance. Although welfare reform officially delinked TANF with other programs such as Medicaid and food stamps, 13 states, including Kansas, elected to cut off Medicaid eligibility as a TANF sanction for work noncompliance (Cheng 2007; Chavkin and Wise 2002; Chavkin, Romero, and Wise 2000). TANF legislation did include requirements for states to provide at least six months of Transitional Medical Assistance (TMA) through Medicaid, but a plethora of research suggests that transitioning to work actually increased the likelihood of insurance instability, especially following the expiration of transitional coverage (Anderson and Eamon 2004; Cheng 2007; Danziger et al. 2008; Hartley, Seccombe, and Hoffman 2005; Holl, Slack and Stevens 2005; Kronebusch 2001; Seccombe, Newsom, and Hoffman 2006).

Even in states where Medicaid eligibility was effectively delinked from TANF, the pressure to discourage welfare enrollment may have indirectly discouraged the use of other programs as well – many low-income women simply did not know that they could qualify for Medicaid even if they were not enrolled in TANF (Chavkin, Romero, and Wise 2000). For example, one study found that only 33 percent of low-income women who left welfare for work were able to get health insurance coverage through their jobs and that rates of uninsurance increased over time as Medicaid coverage declined, resulting in 25-50 percent of former TANF recipients being uninsured 2-3 years later (Garrett and Holahan 2000). Others have found health insurance employment eligibility rates as low as 15 percent among TANF leavers (Hartley,

Seccombe, and Hoffman 2005). The ultimate consequence is that low-income women exiting TANF have had less access to necessary regular health care.

Employment

Family formation, social policies, and economic opportunities and constraints directly affect women's employment decisions. Family dynamics and the changing availability and structure of women's employment shape women's perceptions of need and opportunity, influencing their decisions to work (Gerson 1985; Taniguchi and Rosenfeld 2002). For example, whereas marriage may hasten women's reentrance into the workforce, part-time employment often hastens their exit from the labor market, while the availability of higher wages tends to slow women's employment transitions (Taniguchi and Rosenfeld 2002). Whether by choice or force, job changes and/or job loss is one of the biggest reasons for a lack of insurance among the uninsured (Hoffman et al. 2008; Marquis and Kapur 2003). Despite widespread acceptance of this fact, few have examined the unique characteristics of low-income women's job instability and its effect on their insurance instability (for an exception, see Anderson and Eamon 2004).

Employment opportunities certainly affect women's health insurance options (Holahan and Cook 2008b). Perhaps more interesting though, research on women's labor supply shows that access to health insurance also directly affects women's employment decisions (Adams 2004; Bradley et al. 2007; Buchmueller and Valletta 1999; Wellington and Cobb-Clark 2000). Many women are working more hours then they would prefer in order to secure health insurance benefits for their families (Buchmueller and Valletta 1999). Wellington and Cobb-Clark (2000:316) find that when a married man has access to insurance, the hours his wife works decreases 7-15 percent annually; when a married woman has access to insurance, the hours her

husband works decreases less than 4 percent annually. Some find that parents who have health insurance coverage for themselves or whose children are enrolled in a plan through their employment are less likely to willfully exit a job (Marquis and Kapur 2003). And others show that even when they experience a health shock, women who maintain employment-contingent health insurance are less likely to reduce their labor supply or exit work than women who have insurance through their spouse in order to maintain their insurance coverage (Bradley et al. 2007).

Low-income women's employment trajectories are diverse and influenced by factors such as mental health, family violence, human capital, educational opportunities (Acs and Blumberg 2001; DeNavas-Walt, Proctor, and Smith 2008), access to resources such as a working vehicle (Yoshikawa et al. 2006), and changes in social policy (Hays 2003). Low-income women's wages are often critical for their family well-being (Edin and Lein 1996, 1997; Hays 2003; Johnson 2002). Nevertheless, many low-income women are keenly aware that the kinds of employment they have access to often do not provide benefits or a sufficient wage that will allow them to afford employer-based or private health insurance for themselves and their children (Hartley, Seccombe, and Hoffman 2005). Thus, low-income women who do not have employer-based coverage sometimes resort to other strategies to secure health insurance, such as limiting their work hours in order to remain qualified for public health insurance (Hartley, Seccombe, and Hoffman 2005).

Marriage and Family

A secondary wage-earner has the potential to significantly alter a low-income family's economic status, while lack of access to a partner increases women and children's risk of poverty

(Meyer and Herd 2007; Stacey 1998 [1990]). Despite this, single, female-headed families are increasing as a result of economic and cultural changes that have made traditional families less stable (Lichter, McLaughlin, and Ribar 1997; Zinn 1990). Although the demand for female labor has resulted in more dual-earner families (Cotter, Hermsen, and Vanneman 2001), globalization and deindustrialization are causing greater economic insecurity, inequality, and poverty, especially for low-income, single-parent, and minority families (Abramovitz 1991; Cheal 1996).

Marriage is not a haven for low-income women. Although many low-income women want to marry, they are often unwilling to assume the risk of dependency to economically unstable men or to endure the family violence that often accompanies economic strain (Edin and Kefalas 2005; Rogers-Dillon and Haney 2005). While 67 percent of near-poor women are married, only 37 percent of low-income women are married (Wyn et al. 2001:9). In addition to being more likely to be unmarried, low-income women are also more likely to be single mothers. The rate of single motherhood among near-poor women is about 7 percent, whereas the rate of single motherhood among low-income women is about 29 percent (Wyn et al. 2001:9).

Health insurance is a family matter and a lack of access to insurance for even some family members puts entire households at risk for insurance instability (Institute of Medicine 2002; Schwartz 2007). Spouses play a particularly important role in securing health insurance for many women (Institute of Medicine 2002). Overall, of women enrolled in employment-based insurance, 52 percent are covered directly as an employee and 48 percent are covered as the dependent of an employee (Hoffman et al. 2008:2). Although women are more likely to access employer-based insurance through a spouse, because of changes in marital relationships, dependent coverage is a much less stable form of insurance for women (Anderson and Eamon 2004; Patchias and Waxman 2007; Wyn et al. 2001).

Even when in stable relationships, the health insurance advantages of marriage may not translate for low-income women. For example, Angel, Frias, and Hill (2005) find evidence that low-income families may face a marriage penalty for health insurance, in that being married actually lowers the odds of complete household coverage among low-income families. Marriage and the pooling of resources often disqualify low-income families from public health insurance, although the kinds of work they have access to may not provide affordable benefits in return, leaving low-income families partially or entirely uninsured (Angel, Frias, and Hill 2005)**.** As men's employment becomes more unstable, more women are trying to get insurance through their own employment (Merzel 2000).

Race and Ethnicity

Understanding the relationship between welfare, work, and family changes on low-income women's health insurance and poverty status also requires considering important patterns in insurance access by race. Overall statistics show that 19.5 percent of Blacks and 32.1 percent of Hispanics are uninsured compared to 10.4 percent of whites (DeNavas-Walt, Proctor, and Smith 2008:21; Hoffman et al. 2008). In addition to being at greater individual risk, Blacks and Hispanic-Mexicans also have an elevated risk of incomplete household coverage (Angel, Frias, and Hill 2005). When we focus in on racial disparities in health insurance access among the population of low-income women, several important patterns emerge. For example, whereas low-income Latina women have the highest rates of uninsurance (51 percent), there is no race disparity between low-income Black and white women in the proportion of uninsured – in both populations about one-third do not have health insurance (Wyn et al. 2001:31).

Nevertheless, source of health insurance varies considerably across race and ethnic groups. Research shows that employment often provides the best pathway to health insurance coverage, but groups like Hispanics are significantly less likely to be offered coverage through their work than whites (Zuvekas and Taliaferro 2003). In fact, low-income Latina women have the lowest rates (12 percent) of job-based health insurance coverage (Wyn et al. 2001:32). Whereas a larger proportion of Black low-income women get health insurance through Medicaid (33 percent), white low-income women have the highest proportion of job-based dependent coverage (18 percent) (Wyn et al. 2001:32).

One significant consequence of welfare reform is that immigrant and minority women now report greater difficulties in getting insurance and delays in receiving medical care (Kaushal and Kaestner 2007). Because more low-income Black women rely on Medicaid as a source of health insurance than other groups of women, welfare reform has had much more of an impact on their health insurance access. Further contributing to racial disparities in health insurance, welfare reform effectively banned new immigrants from Medicaid coverage (Wyn et al. 2001). Although 86 percent of low-income women are either U.S. born or immigrant citizens (4 percent), low-income women born outside of the U.S. have seen the greatest reductions in Medicaid coverage and the greatest increases in uninsurance. In fact, 56 percent of low-income noncitizen women are uninsured (Wyn et al. 2001: 40). Research consistently shows that race, nativity, and city of residence have important effects on the insurance status of low-income women (see Angel, Frias, and Hill 2005; Taniguchi and Rosenfeld 2002; Zuvekas and Taliaferro 2003).

Limitations of Previous Research

Expanding our understanding of the complex relationship between welfare, work, and family changes, health insurance instability, and changes in poverty status, requires a longitudinal analysis of individual-level data that allows us to model the dynamic nature of low-income women's lives and health insurance coverage (Angel, Frias, and Hill 2005). Many low-income women live on the edge of poverty daily, making changes in their work, family, and welfare status particularly consequential for their economic well-being.

Although cross-sectional analyses of health insurance coverage provide important information about the distribution of health insurance access at any given time, they may not adequately represent the fluctuating life circumstances of low-income workers, the contingent nature of insurance eligibility, or the long-term effects of prior conditions. Such models may work well for describing families who have access to stable sources of employment and economic resources, but are less appropriate for describing the lives of low-income women who are more likely to face frequent job changes and/or job loss resulting in a disruption of health insurance coverage (Dodson and Bravo 2005; Dubay and Kenney 2004; Feder et al. 2001; Schoen and Puleo 1998; Tallon and Rowland 2007; Wyn et al. 2001; Yoshikawa et al. 2006). Thus, if we only examine insurance status at one point in time, then we severely underestimate the risks associated with being unstably insured (Graefe and Short 2003; Schoen and DesRoches 2000). Therefore, analyzing a panel of low-income women living in low-income neighborhoods provides the ideal opportunity to examine the effects of individual-level changes on low-income women's insurance instability and poverty status over time.

In addition, research examining the lives of low-income women often treats those with incomes below 200 percent of the Federal Poverty Level (FPL) as one cohesive group. There is some justification for grouping these women together for comparative purposes, but we also

know there is a great deal of variability among categories of the poor (Iceland 2003). As McCall (2000) describes, the "new inequality" is *between* groups of women. As opportunities for some women have improved, others have eroded. Thus, it is vital that we look at within gender variability when examining women's lives. Edin and Lein (1997), for example, make the important distinction between "welfare reliant" and "wage reliant" women in their in-depth analysis of low-income women's lives post welfare reform. Although these women share many of the same social and economic struggles, their strategies for survival are somewhat different based on their relationship to the labor market and welfare state. Utilizing a welfare regime perspective causes us to consider the "family reliant" woman and the unique constraints she faces in maintaining health insurance. Are the effects of welfare, work, and family changes on women's health insurance stability and poverty consistent across categories of low-income women? Or are certain changes more or less consequential for poor and near-poor women?

Finally, because of their unique vulnerabilities, general population data may not accurately represent low-income women's experience. Immediately following welfare reform and up to five years later (when some women would begin hitting the five year time-limit on benefits) there was a plethora of research examining the consequences of welfare-to-work programs on the lives of low-income women. Some of this work did include examining the effects of welfare reform on women's health insurance access. But soon after this work was accomplished, the attention of health insurance scholars turned to examining the effects of skyrocketing health care costs on the middle-class (i.e., Pandey and Cantor 2004). What has happened to low-income women 10 years after welfare reform? What changes have these women endured? And what are the consequences of these changes on low-income women's access to health insurance and economic progress?

In order to assess how changes in women's work, family, and welfare situations affect changes in their access to health insurance, and the effects of health insurance stability on low-income women's poverty, I will conduct a secondary analysis of three waves of data from the *Welfare, Children, and Families Project: A Three-City Study* using a series of logistic regression models. The analysis will be driven by three specific research questions. Informed by existing research several hypotheses have been generated.[3]

Research Question 1

What is the relative importance of individual-level welfare, work, and family factors in predicting low-income women's health insurance access over time?

Hypotheses Set 1

I hypothesize that there will be differential effects for low-income women's welfare, work, and family changes dependent upon the type of insurance examined.

H1a: Given the economic benefits of full-time employment, in the Chapter 4 lagged effects models I expect to find that full-time employment at T1 will have strong and consistent effects across models predicting women's insurance access at T2; full-time employment at earlier time points should reduce women's odds of being uninsured or publicly insured, and increase their odds of having access to private or employment based insurance at later time points. Similarly, in Chapter 5 I expect to find that employment changes that result in access to full-time work will

[3] Because my first research question is primarily descriptive, it may seem inappropriate to formulate strict hypotheses. Nevertheless, for the purposes of this dissertation I have offered some specific hypotheses describing my expectations regarding the relationships between certain variables in order to guide discussion of my statistical findings in later chapters.

have effects consistent with stable access to full-time employment, resulting in increased likelihood of being privately insured and reduced likelihood of being uninsured or having public insurance. In Chapter 6 I also expect to find that employment trajectories that reflect stable and continuous access to full-time work will increase women's odds of having private or employment based insurance while reducing their odds of being uninsured or having public insurance. Nevertheless, it is also possible that because of the kinds of work low-income women have access to (low-pay, low-skill occupations), full-time employment (particularly new full-time employment) may not provide sufficient protection against being uninsured or guarantee access to private or employment based insurance options.

H1b: Although Medicaid was officially delinked from welfare receipt in 1996, I expect to find that women's welfare status will have a significant effect on women's access to public insurance, but less of an impact on their access to private insurance. For example, in Chapter 4 I expect to find that women on welfare at T1 are more likely to have public insurance and less likely to have private or employer based insurance at T2. Because of the protection public insurance provides to low-income women, we could also reasonably expect to find that women on welfare at T1 may also be less likely to be uninsured at T2. Similarly, in Chapter 5 I expect to find that changes that results in women's loss of welfare benefits will also negatively impact their access to public health insurance. Given the economic vulnerability following loss of welfare benefits, we might also expect to find that these women are more likely to be uninsured and less likely to have private or employment based insurance. In Chapter 6 I can reasonably expect to find that women with trajectories displaying either stable access to welfare or new access to welfare are

more likely to have access to public insurance and less likely to be uninsured or have private or employment based insurance.

H1c: I also hypothesize that marriage stability will increase the likelihood of having private insurance, while simultaneously reducing the likelihood of having public insurance or being uninsured. Given the economic benefits of marriage, in Chapter 4 I expect to find that marriage at T1 will reduce women's odds of having access to public insurance and being uninsured, while increasing their odds of having access to private or employment based insurance at T2. In Chapter 5, I also expect to find that getting married or staying married have similar effects – reducing women's access to public insurance and odds of being uninsured, while increasing their odds of having private or employment based benefits. Similarly, in Chapter 6 I expect to find that trajectories that do not lead to formal marriage will have minimal effects on women's access to private or employment based insurance or uninsured status, while increasing women's odds of access to public insurance. Despite the potential for resource pooling among cohabiting couples, across all models I suspect that cohabitation will not have the same level of effects on women's access to insurance as formal marriage. Nevertheless, as expressed in hypothesis H1a, because of the kinds of work low-income men often have access to, it is also possible that marriage, while reducing women's access to public insurance and providing opportunities to qualify for employer health insurance as a dependent, may not provide sufficient protection against being uninsured or guarantee access to private or employment based insurance options.

H1d: Finally, in Chapters 5 and 6 I hypothesize that although static measures of women's welfare, work, and family statuses may help us predict their insurance status, measures of change

and trajectory will do a better job of explaining the variance in women's health insurance status by better accounting for the dynamic nature of low-income women's lives. Similarly, although in Chapter 4 I expect to observe the lagged effects described above, I also expect to find that measures of the lagged effects of static status are less helpful in explaining the variance in women's insurance status than change or trajectory measures.

Research Question 2

Are there significant differences between women who are poor and near-poor at Wave 1 in the effects of welfare, work, and family factors on their health insurance access over time?

Hypotheses Set 2

I hypothesize that there will be significant differences between poor and near-poor women in the importance of various welfare, work, and family factors due to poor women's increased vulnerability. Nevertheless, I expect that the significance of differences between poor and near-poor women will be dependent on the type of insurance instability analyzed.

H2a: Because of poor women's ability to qualify for public health insurance (despite the strict eligibility guidelines) I expect to find that employment factors will have relatively little impact on their access to any form of insurance but may have more profound effects for near-poor women. For example, in Chapter 4 I expect to find that near-poor women's access to full-time employment at T1 will make them more likely to have private or employer based insurance at T2, whereas poor women's access to full time employment will not provide the same benefit due to their particularly low wages and access to public insurance options. In Chapter 5 we might

similarly expect to find that employment changes that result in access to full-time employment may not provide poor women the same benefits in terms of access to private or employment based insurance due to their low wages. Consistent with this, I expect to find in Chapter 6 that trajectories leading to full-time employment will have less significant effects for poor than near poor women.

H2b: I expect to find that poor women's welfare receipt will have more pronounced effects on their access to insurance and poverty than near-poor women. For example, in Chapter 4 I anticipate that poor women's access to welfare at T1 will increase their likelihood of being publicly insured and reduce their likelihood of being uninsured or privately insured at T2, and that these effects will be more pronounced for poor women than near-poor women. In Chapter 5 I hypothesize that even when they experience welfare changes poor women will have a greater likelihood of being publicly insured and a reduced likelihood of being uninsured, whereas near-poor women who experience welfare changes may not benefit from these same protections. Nevertheless, near-poor women's loss of welfare status may result in greater likelihood of obtaining private or employer based insurance, whereas poor women may not obtain similar access to private or employer based benefits upon loss of welfare. Finally, in Chapter 6 I expect to find that even when poor women experience less stable welfare trajectories (i.e., lose welfare benefits) they will experience less significant impacts on their health insurance access than near-poor women who, when loosing welfare benefits, may be at greater risk of losing public health insurance and being uninsured than poor women.

H2c: I also hypothesize that family factors will have a much greater impact on near-poor women's access to public insurance and risk of being uninsured than poor women as poor women's access to public programs protects them better from the negative effects of family changes than near-poor women. For example, in Chapter 4 I expect to find that near-poor women's marital status at T1 plays a more significant role in affecting their access to both public and private insurance at T2 than poor women, namely, by reducing their likelihood of qualifying for public insurance due to resource pooling, while increasing opportunities for access to employer-based insurance options through marriage. In Chapter 5, I expect to observe that family changes that result in the ending of a marriage or beginning of a marriage will have more significant effects on near-poor women's access to both public and private insurance than poor women. Similarly, I also expect to find in Chapter 6 that trajectories representing stable marriage or movement into marriage will have more profound effects for near-poor women by increasing their access to private insurance while reducing their access to public insurance. I also expect to find that stable cohabitation may not provide the same level of benefits for near-poor women that stable marriage provides given women's ability to access private insurance benefits as dependents through marriage.

Research Question 3

Given the effects of welfare, work, and family factors on low-income women's health insurance access, is health insurance access a significant barrier to low-income women's economic progress over time?

Hypotheses Set 3

Finally, I hypothesize that different forms of insurance access and instability will have differential effects on women's poverty over time.

H3a: I first hypothesize that being uninsured will significantly reduce women's economic progress over time. For example, in Chapter 4 I expect to observe that compared to those who are uninsured at T1, women with private forms of insurance will be less likely to move into poverty and more likely to move out of poverty at T2. In Chapter 5 I also expect to find that becoming uninsured or staying uninsured results in greater risk of moving into poverty and reduced odds of moving out of poverty at T2. Similarly, in Chapter 6, we might expect that trajectories leading to loss of insurance will result in greater odds of moving in to poverty.

H3b: Although I expect to find that having access to public insurance may protect women from the economic costs of health care, it is also possible that the benefits of public insurance access may not be observable or consistent across models because too much economic progress may result in loss of public insurance benefits. So, for example, although in Chapter 4 I anticipate that women's access to public insurance at T1 reduces their odds of moving into poverty at T2 (i.e., by reducing their risk of medical debt, etc.), in Chapter 5, the loss of public insurance may actually represent women's movement out of poverty. Similarly, in Chapter 6 we might also expect to find that stable public insurance trajectories are an indication of sustained poverty over time.

H3c: Finally, I hypothesize that having access to private insurance should improve women's economic progress. For example, in Chapter 4 we might expect to find that access to private or

employer-based insurance at T1 increases the odds of moving out of poverty at T2. Similarly, in Chapter 5 we might expect to find that transitioning into private or employment based insurance increases women's odds of moving out of poverty. And in Chapter 6 we might also expect to observe that trajectories that represent both stable access to and movement into private or employment based insurance produce positive effects on women's economic progress by reducing their odds of moving into poverty. Nevertheless, it is also possible that because of variability in the extensiveness and cost of private insurance, access to this form of insurance may not have consistent effects on women's economic progress over time.

CHAPTER THREE

DATA AND METHODS

Introduction

Examining how low-income women's changing relationships to work, family, and the welfare state affect both their access to health insurance and economic resources requires use of data that are first, representative of low-income families and second, longitudinal by design in order to allow me to adequately examine changes in women's lives over time. Although there are many different sources of data on health insurance access available for public use, I have chosen to use data from the *Welfare, Children, and Families Project: A Three-City Study* to answer my research questions. Interested in the effects of welfare reform on low-income women, children, and families, a large collaborative research team (supported in part by Johns Hopkins University) collected extensive data over a six year period from over 2,000 low-income families regarding their employment opportunities, family arrangements, use of public benefits, health insurance access, and general well-being (Angel et al. 2009).[4] Given the Three-City Study's explicit focus on low-income women and longitudinal research design, I believe these data are ideal for answering my research questions.

[4] Financial support for the study was provided by the following federal agencies and foundations: Eunice Kennedy Shiver National Institute of Child Health and Human Development; Office of Disability, Aging, and Long-Term Care Policy, Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services; Administration on Developmental Disabilities, U.S. Department of Health and Human Services; Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services; Office of Research, Evaluation, and Statistics, Office of Policy, Social Security Administration; National Institute of Mental Health; The Boston Foundation; The Annie E. Casey Foundation; The Edna McConnell Clark Foundation; The Lloyd A. Fry Foundation; Hogg Foundation for Mental Health; The Robert Wood Johnson Foundation; The Joyce Foundation; Henry J. Kaiser Family Foundation; W. K. Kellogg Foundation; Kronkosky Charitable Foundation; The John D. and Catherine T. MacArthur Foundation; Charles Stewart Mott Foundation; The David and Lucile Packard Foundation; and the Woods Fund of Chicago.

The Data

Data for the Three-City Study were collected in 1999 (Wave 1), 2001 (Wave 2), and 2005 (Wave 3) and drawn from a representative sample of low-income families living in low-income neighborhoods in Boston, Chicago, and San Antonio (Angel et al. 2009). These cities were chosen by the principal investigators to reflect the race/ethnic and policy diversity of US cities and states (Coley and Fomby 2008). Research shows that state policy and population composition play an important role in shaping individuals' access to health insurance (Angel, Frias, and Hill 2005; Zimmerman and Legerski 2010). For example, in the late 1990s Massachusetts, Illinois, and Texas were among the top eight states with the largest non-citizen populations (Angel, Frias, and Hill 2005) and among the top 12 states with the largest Medicaid enrollments (Ellis and Smith 2000), yet Medicaid eligibility guidelines for immigrants in each state varied considerably.

Boston was chosen by the principal investigators for inclusion in the Three-City Study because of its large population of African American (29 percent) and Hispanic (11 percent) residents and its historically liberal state government (Coley and Fomby 2008). The poverty rate in Massachusetts in 1999 was 9.3 percent (Bishaw and Iceland 2003:4). Following welfare, from 1996-1998, Massachusetts experienced a 27 percent decline in TANF recipients – which although significant, actually represents a rate much lower than the U.S. average decline of 32 percent (Chavkin, Romero and Wise 2000: 902). Despite imposing strict workfare requirements and a family cap in aid, the state's TANF amendments also included a number of measures intended to support recipients, including guaranteed childcare and support for victims of family violence (Chavkin, Romero and Wise 2000). During the 1990s the state was experimenting with a mix of state-based and market-based health insurance reforms (Barrilleaux and Brace 2007).

While most states were experiencing declines in Medicaid enrollments during this time, Massachusetts actually posted consistent gains in Medicaid enrollment following implementation of the Mass Health program which expanded eligibility for working adults in categories that do not normally qualify for Medicaid (Ellis and Smith 2000). From 1999-2005 the state's non-elderly uninsured population fluctuated around ten percent (U.S. Census 2009). State legislation supporting universal healthcare coverage was signed into law in 2006, reducing the state's non-elderly uninsured population to six percent, but this did not occur until after the third wave of data were collected (U.S. Census 2009). Despite the overall improvement, by the end of the study period (2006-2007) the state's proportion of uninsured non-elderly, low-income women remained at about 16 percent (Kaiser Family Foundation 2008c).

Chicago was chosen as the second site for its large population of African American (39 percent) and Hispanic (19 percent) residents and its historically moderate state government (Coley and Fomby 2008). The poverty rate in Illinois in 1999 was 10.7 percent (Bishaw and Iceland 2003:4). Like Massachusetts, following welfare reform (1996-1998) Illinois experienced a 25 percent decline in TANF enrollments (Chavkin, Romero and Wise 2000: 902). With the exception of imposing a family cap in aid and guaranteeing childcare for TANF recipients, the state did not make many other amendments to the new federal welfare regulations (Chavkin, Romero and Wise 2000). During the 1990s the state was also experimenting with market-based health insurance reforms (Barrilleaux and Brace 2007) and experienced both periods of growth and loss in Medicaid enrollments (Ellis and Smith 2000). From 1999-2005 the state's non-elderly uninsured population fluctuated around 15 percent (U.S. Census 2009). Despite a relatively low overall rate of uninsured, the state's proportion of uninsured low-income women (non-elderly)

remained much higher at 34 percent following the study period, from 2006-2007 (Kaiser Family Foundation 2008c).

Finally, San Antonio was chosen for its large population of Hispanic (55 percent) and African American (7 percent) residents and its historically limited state government (Coley and Fomby 2008). The poverty rate in Texas in 1999 was 15.4 percent (Bishaw and Iceland 2003:4). Following welfare reform (1996-1998) Texas experienced a 44 percent reduction in TANF enrollments after instituting a number of deterrent policies, such as offering one-time cash payments to delay application for TANF and requiring recipients to attend family planning counseling and/or educational activities (Chavkin, Romero and Wise 2000: 902). Although federal welfare reform prevented new immigrants from receiving TANF for five years after entering the U.S., Texas extended the ban until new immigrants receive citizenship (Frazer, Gold, and Lyons 1999). The state's welfare reform program also resulted in significant declines in Medicaid enrollment by discouraging applicants from seeking any form of state assistance (Frazer, Gold, and Lyons 1999; Ellis and Smith 2000). Exceptionally restrictive financial eligibility criteria and mandatory face-to-face recertification made Texas "one of the 10 most limited Medicaid programs in the nation" (Frazer, Gold, and Lyons 1999:8). Perhaps unsurprising, the state's focus on health insurance reforms in the 1990s emphasized market-based approaches and limited state government (Barrilleaux and Brace 2007; Frazer, Gold, and Lyons 1999). From 1999-2005 the state's non-elderly uninsured population fluctuated around 26 percent – well above the national average (U.S. Census 2009). Even more notable is the state's rate of uninsured low-income women (non-elderly), which at 51 percent in 2006-7 represented the highest rate of uninsured low-income women in the nation (Kaiser Family Foundation 2008c).

The completion of the third survey of the Three-City Study provides an ideal opportunity to examine the effects of low-income women's welfare, work, and family transitions on their access to health insurance, the role of health insurance instability as a barrier to women's economic progress, and differences in the nature of these relationships between categories of low-income women. Although many scholars are using this data to examine various aspects of low-income families, previous research has not yet taken advantage of the time dimensions of the dataset. For example, Angel, Frias, and Hill (2005) have used Wave 2 data to examine the correlates of child coverage and household insurance coverage, their analysis was cross-sectional, and they did not examine how employment changes over time affect insurance status over time. Similarly, Cherlin and Fomby (2004) have used Wave 1 and Wave 2 data to examine how work and welfare transitions influence marriage transitions, but they did not analyze how these transitions influence health insurance access over time. The timing of the second data collection in 2001 is particularly important given that it marked the five year anniversary of PRWORA, and meant some women would begin to reach the five year time limit on welfare benefits. From a historical perspective, these data allow us to examine the condition of low-income women nearly 10 years after welfare reform, providing the opportunity to assess the long-term consequences of welfare-to-work policies on low-income women's health insurance status and the role of health insurance instability as a barrier to women's economic progress.

Sampling

The principal investigators utilized a population based sampling strategy for selecting participants. The first sampling stage included random selection of high-poverty neighborhoods (Census blocks with a 20 percent poverty rate or higher) stratified by the predominant

race/ethnicity of each neighborhood in each of the three cities. Within each neighborhood a random segment of households was selected. Then within each segment of households, dwelling units were randomly sampled for screening. A total of 40,000 households were selected for screening based on eight stratifying criteria, including household head's race/ethnicity, family income, female caregiver's marital status, age of children in the home, and receipt of social services such as Medicaid or food stamps. The actual sampling unit was a single focal child within the household, but data were also collected from that child's primary female caregiver.

Of the qualifying households, 2,402 families participated in interviews at Wave 1 (for a response rate of 74 percent). Of the children and families interviewed at Wave 1, 80 percent were re-interviewed at Wave 3 (N=1,921), but 131 children were living with new female caregivers at Wave 2 and Wave 3. In addition to surveying these new caregivers, every effort was also made to collect data from the separated caregiver at Wave 2 and Wave 3 (if still separated at this time). Data from the 131 new caregivers are excluded from my analysis since no data was collected from them at Wave 1. Thus, the valid response rate for my study of families participating at all three time points is 74.5 percent of the original Wave 1 respondents (N=1,790). The results of my analysis are based on only the data collected from the primary female caregivers who participated in all three surveys. Although not shown here, comparisons between panel respondents and those who did not participate in all three surveys reveal minimal differences between groups, with the only statistically significant difference being that panel respondents were more likely to be from Chicago and San Antonio. Greater attrition among Boston respondents provides further justification for the use of household panel weights to correct for any biases in point estimates.

Since I am primarily interested in women's access to Medicaid and private/employer based insurance, I also exclude from the models 82 individuals who had military or other forms of health insurance as well as 46 respondents who had both public and private/employer insurance simultaneously since these women represent a small, yet special case (N=1,662).[5]

There are many ways to utilize longitudinal data, each providing a different way of measuring the changes women experience over time. In this dissertation I have chosen to focus on three different kinds of longitudinal measures in order to provide a more nuanced understanding of low-income women's access to health insurance and poverty over time. In Chapter 4 I model the lagged effects of welfare, work, and family factors at T1 on women's health insurance and poverty status at T2. Understanding the effects of a set of conditions at one time point on women's opportunities at later time points provides us with a long-term perspective and may allow us to develop better interventions that will help women "down the road." While Chapter 4 examines the lagged effects of T1 measures, in Chapter 5 I take a different approach by using measures of welfare, work, and family change to predict women's health insurance and poverty status. By comparing models using static measures with models using measures of change I can determine if experiencing change in any particular status impacts women's health insurance access and poverty differently than one's current marital, employment, or welfare status. Then in Chapter 6, I examine change over time by using trajectory measures to explore how welfare, work, and family patterns prior to Wave 3 might affect women's access to health insurance and poverty status. Some argue that trajectories are better able to represent the dynamic nature of people's lives than simple cross-sectional measures of individual characteristics. Instead of measuring one's status at a certain time point, trajectories

[5] Comparisons between those included in the analyses and those dropped because they had military/other insurance or multiple forms of insurance simultaneously (results not shown) reveal few statistically significant differences between groups. The exceptions being that those dropped tend to be older and/or have fewer children.

give us important information about an individual's experience prior to their current status, which may help explain variation between respondents who share a similar status at Wave 3, for example. After all, *how* a person arrived at a certain place may play a role in their ability to access certain opportunities at any given point in time.

I chose several variables to represent the welfare, work, and family factors that may affect low-income women's health insurance access and poverty status. Tables 3.1a-c display summaries of the independent and dependent variables used in the models. Although the models use many of the same variables, the data collection time points vary and in some cases the response categories and coding of certain variables also varies, thus variables for each set of analyses are described separately where appropriate.

Table 3.1a Variable Descriptions for Chapter 4 Lagged Effects Models

Independent Variables		
Controls	Time	Data collection time point identifier (Wave 1 or 2)
	Months	Months between collection points
	City	Boston, Chicago, San Antonio
	Race/Ethnicity	White, Black, Hispanic, Other
	Citizenship	US Citizen, No or Yes (Wave 1 or Wave 2)
	Kids	# of Children in Household Responsible for (Wave 1 or 2)
	Age	Respondent Age in years (Wave 1 or 2)
Employment Factors	Education	No Degree, HS Diploma/GED, College Degree (Wave 1 or 2)
	Employment	Unemployed, Work < 35 hours, Work 35+ hours (Wave 1 or 2)
	Income	Total Household Income in Thousands (Wave 1 or 2)
Welfare Factors	Welfare	On Welfare, No or Yes (Wave 1 or 2)
Family Factors	Marital Status	Single (not cohabiting), Cohabiting, Separated/Spouse Not Present, Married (spouse present) (Wave 1 or 2)
Health Factors	Health	General Health Excellent/Very Good, Good, Fair/Poor (Wave 1 or 2)
	Health Problem	Health Problem Prevents Working, No or Yes (Wave 1 or 2)
	Health Need	Could Not Afford Needed Care, No or Yes (Wave 1 or 2)
	Uninsured	Uninsured, No or Yes (Wave 1 or 2)
	Public HI	On Medicaid, No or Yes (Wave 1 or 2)
	Private/Employer	Have Private/Employer HI, No or Yes (Wave 1 or 2)
Poverty Status	Poor	In Poverty (Total Household Income < FPL), No or Yes (Wave 1 or 2)
Dependent Variables		
	Uninsured	Uninsured, No or Yes (Wave 2 or 3)
	Public	Enrolled in Medicaid, No or Yes (Wave 2 or 3)
	Private/Employer	Enrolled in Private or Employer HI, No or Yes (Wave 2 or 3)
	Poverty Change	Changed poverty status by T2, No or Yes (Wave 2 or 3)

Table 3.1b Variable Descriptions for Chapter 5 Change Variable Models

Independent Variables		
Controls	Time	Data collection time point identifier (Time 2 or 3)
	Months	Months between collection points
	City	Boston, Chicago, San Antonio
	Race/Ethnicity	White, Black, Hispanic, Other
	Citizenship	US Citizen, No or Yes (Wave 2 or 3)
	Kids	# of Children in Household Responsible for (Wave 2 or 3)
	Age	Respondent Age in years (Wave 2 or 3)
Employment Factors	Education	No Degree, HS Diploma/GED, College Degree (Wave 2 or 3)
	Income	Total Household Income in Thousands (Wave 2 or 3)
	Employment	Unemployed, Work < 35 hours, Work 35+ hours (Wave 2 or 3)
	Employment Change	Stayed < FT Employed, Lost FT Employment, Got FT Employment, Stayed Employed FT (Wave 2 or 3)
Welfare Factors	Welfare	On Welfare, No or Yes (Wave 2 or 3)
	Welfare Change	Stayed On Welfare, Moved On Welfare, Moved Off Welfare, Stayed Off Welfare (Wave 2 or 3)
Family Factors	Marital Status	Single (not cohabiting), Cohabiting, Separated/Spouse Not Present, Married (spouse present) (Wave 2 or 3)
	Marriage Change	Stayed Unmarried, Left Marriage, Got Married, Stayed Married (Wave 2 or 3)
Health Factors	Health	General Health Excellent/Very Good, Good, Fair/Poor (Wave 2 or 3)
	Health Problem	Health Problem Prevents Working, No or Yes (Wave 2 or 3)
	Health Need	Could Not Afford Needed Care, No or Yes (Wave 2 or 3)
	Insurance Change	Stayed Uninsured, Lost Insurance, Got Insurance, Stayed Insured (Wave 2 or 3)
	Public HI Change	Stayed On Public HI, Got On Public HI, Lost Public HI, Stayed Off Public HI (Wave 2 or 3)
	Private/Employer HI Change	Stayed Off Private/Employer HI, Lost Private/Employer HI, Got Private/Employer HI, Kept Private/Employer HI (Wave 2 or 3)
Poverty Status	Poor	In Poverty (Total Household Income < FPL), No or Yes (Wave 1 or 2)
Dependent Variables		
	Uninsured	Uninsured, No or Yes (Wave 2 or 3)
	Public HI	Enrolled in Medicaid, No or Yes (Wave 2 or 3)
	Private/Employer	Enrolled in Private or Employer HI, No or Yes (Wave 2 or 3)
	Poverty Change	Changed poverty status by T2, No or Yes (Wave 2 or 3)

Table 3.1c Variable Descriptions for Chapter 6 Trajectory Models

Independent Variables		
Controls	City	Boston, Chicago, San Antonio
	Race/Ethnicity	White, Black, Hispanic, Other
	Citizenship	US Citizen, No or Yes (Wave 3)
	Kids	# of Children in Household Responsible for (Wave 3)
	Age	Respondent Age in years (Wave 3)
Employment Factors	Education	No Degree, HS Diploma/GED, College Degree (Wave 3)
	Income	Total Household Income (Wave 3)
	Employment	Unemployed, Work < 35 hours, Work 35+ hours (Wave 3)
	Employment Trajectory	Continuously Unemployed, Became Unemployed, Stayed or Moved Into PT Work, Continuously FT Employed, Moved Into FT Work (by Wave 3)
Welfare Factors	Welfare	On Welfare, No or Yes (Wave 3)
	Welfare Trajectory	Continuously Off Welfare, Moved Off Welfare, Continuously On Welfare, Moved Onto Welfare (by Wave 3)
Family Factors	Marital Status	Single (not cohabiting), Cohabiting, Separated/Spouse Not Present, Married (spouse present) (Wave 3)
	Marriage Trajectory	Continuously Single, Became Single, Started or Stayed Cohabiting, Continuously Married, Got Married, Continuously Separated or Spouse Not Present, Moved Into Separation (by Wave 3)
Health Factors	Health	General Health Excellent/Very Good, Good, Fair/Poor (Wave 3)
	Health Problem	Health Problem Prevents Working, No or Yes (Wave 3)
	Health Need	Could Not Afford Needed Care, No or Yes (Wave 3)
	Insurance	Uninsured, Medicaid, Private or Employer HI (Wave 3)
	Insurance Trajectory	Continuously Uninsured, Became Uninsured, Continuous Public HI, Moved Into Public HI, Continuous Private/Employer HI, Moved Into Private/Employer HI (by Wave 3)
Poverty Status	Poor	In Poverty (Total Household Income < FPL), No or Yes (Wave 1)
Dependent Variables		
	Uninsured	Uninsured, No or Yes (Wave 3)
	Public HI	Enrolled in Medicaid, No or Yes (Wave 3)
	Private/Employer	Enrolled in Private or Employer HI, No or Yes (Wave 3)
	Poverty Change	Changed poverty status by W3, No or Yes (Wave 3)

Dependent Variables

In this analysis I am primarily interested in the factors that affect low-income women's access to public and private or employer based insurance and their risk of being uninsured or in poverty. Thus, the dependent variables of interest in the following chapters include: women's health insurance status (uninsured versus insured), access to public health insurance (on Medicaid or not), access to private or employer based insurance (enrolled in a private/employer health insurance plan or not) and change in poverty status (fell below the FPL or not). Since few respondents indicated they had military or other health coverage, I do not examine predictors of these forms of insurance coverage.

Uninsured: Respondents were asked if they were covered by any health insurance. Those who indicated No, they did not have any form of health insurance, are coded as 1, while those who indicated Yes, they had some form of health insurance, are coded as 0.

Public HI: Respondents who indicated they were covered by some form of health insurance were asked if they were covered by Medicaid. Those who indicated No, they were not on Medicaid, are coded as 0, while those who indicated Yes, they were enrolled in Medicaid, are coded as 1.

Private/Employer HI: Respondents were also asked if they were covered by private or employer based health insurance. Those who indicated No to either question are coded as 0, while those who indicated Yes, they were enrolled in either private or employer based insurance, are coded as 1.

Poverty Change: Change in women's poverty status is measured as a categorical variable. Respondents who maintained their poverty status across time points are coded as 0, while respondents who experienced a change in their poverty status are coded as 1.

Grouping Variable

Because poverty status affects women's ability to qualify for public programs, poverty status is treated as a grouping variable in some models. Separating analyses by women's poverty status at T1 allows me to look for differences between poor and near-poor women in the effects of welfare, work, and family factors that shape low-income women's risk of being uninsured and their access to private and public forms of insurance. I calculated women's poverty status using the Health and Human Services 1999, 2001, and 2005 Poverty Guidelines and data collected on women's total household income (from all sources) and the total number of household members. Consistent with other analyses, those with total household incomes 100 percent or less of the FPL are defined as poor and coded as 1.

All women selected for inclusion in the study were considered low-income at T1 – meaning they had total household incomes less than 200 percent of the FPL. Although women's incomes changed over time, most women included in this study remained low-income across all three time points. In the literature, those with incomes between 100 percent and 200 percent of the FPL are typically considered near-poor. Nevertheless, in the following analyses I group all women with total household incomes above 100 percent of the FPL in the near-poor category, which is coded as 0.

Employment Independent Variables

Access to stable, full-time employment can provide access to health insurance through an employer and may affect one's eligibility for public forms of insurance. Educational attainment plays an important role in shaping the kinds of work one has access too. Both factors influence the income of respondents.

Education: Respondents were asked to indicate their highest educational degree or certificate earned by the time of the interview. Responses were recoded to reflect three major response categories: No Degree, High School Diploma or General Education Degree (GED, including a Vocational Tech Diploma), and College Degree (defined as an Associate's Degree or higher). Educational status is included in each of the models as a series of dummy variables where those with No Degree serve as the reference category. Using imputation by chained equations I imputed values for respondents with missing data (described below).

Employment: Respondents were asked how many hours they usually worked per week at their main job. Those who indicated they worked 35 hours or more per week are classified as Working Full-time. Those who worked 1-34 hours per week are classified as Working Part-Time. The few individuals who indicated that their work hours varied from week to week are grouped with those working part-time because like part-time work, variable work schedules often disqualify workers from access to standard full-time benefits such as health insurance. Employment status is included in each of the models as a series of dummy variables where those who are Unemployed (working no hours) serve as the reference category.

Income: Income represents a ratio level measure of total monthly household income per $1,000. Using imputation by chained equations I imputed values for respondents with missing data (described below). Total household income is more appropriate to use than individual income in this context since household income is often used to determine eligibility for public programs. Although I tested for the appropriateness of using income-squared and income-cubed in the models (in order to reflect a curvilinear relationship between income and insurance status) neither transformation significantly improved the fit of the model or changed the results of the analyses, so transformations of income were not used in any of the models presented here.

Employment Change: For Chapter 5 I created a change variable to reflect changes in women's employment status at Times 2 and 3. Because working full time appears to have the strongest impact on women's insurance access and poverty, only transitions into and out of full-time employment were coded. The employment change categories include: those who Stayed Less than FT Employed at Times 2 and 3, those who Lost FT Employment, those who Got FT Employment, and those who Stayed Employed FT at Times 2 and 3. Employment change is included in each of the models as a series of dummy variables where those who Stayed Less than FT Employed serve as the reference category.

Employment Trajectory: For Chapter 6 I created a trajectory variable to reflect changes in women's employment status over all three data collection time points. Although a total of 27 unique trajectories were observed, categories were grouped to reflect five basic

trajectories determined by women's status at Wave 3: those who were Continuously Unemployed across all three time points, those who Became Unemployed by Wave 3, those who Stayed or Moved Into PT Work by Wave 3, those who were Continuously Employed FT across all three time points, and those who Moved Into FT Work by Wave 3. Employment Trajectory is included in each of the models as a series of dummy variables where those who were Continuously Unemployed across all three time points serve as the reference category.

Welfare Independent Variables

Although welfare status was technically delinked from Medicaid with welfare reform, many states use the same eligibility criteria for both public programs and several states maintain Medicaid penalties for TANF violations. Thus, in many states welfare status maintains a direct relationship with one's access to Medicaid.

Welfare Status: Respondents were asked if they were currently receiving welfare at the time of the interview. Those who indicated they were On Welfare are coded as 1 while all others are coded as 0.

Welfare Change: For Chapter 5 I created a variable to measure changes in women's welfare status at Times 2 and 3. The categories of responses include: Those who Stayed Off Welfare at either Time 2 or 3, those who Got Off Welfare, those who Got On Welfare, and those who Stayed On Welfare. Welfare change is included in each of the models as a series of dummy variables where those who Stayed Off Welfare at either Time 2 or 3 serve as the reference category

Welfare Trajectory: For Chapter 6 I created a trajectory variable to reflect changes in women's welfare status over the three data collection time points. Although a total of eight unique trajectories were observed, categories were grouped to reflect four basic trajectories determined by women's welfare status at Wave 3: those who were Continuously Off Welfare across all three time points, those who Moved Off Welfare by Wave 3, those Continuously On Welfare across all three time points, and those who Moved Onto Welfare by Wave 3. Welfare Trajectory is included in each of the models as a series of dummy variables where those who were Continuously Off Welfare across all three time points serve as the reference category.

Family Independent Variables

Women's marital status has important implications for their access to health insurance options. For example, married women are significantly more likely to access employer-based insurance through a spouse. In many cases marital status may also affect one's access to public programs.

Marital Status: Respondents were asked to indicate their marital and cohabitation status. Responses were grouped into four categories: those who indicated they were Single (and Not Cohabitating), Cohabiting, Separated or Spouse Not Present, and Married (Spouse Present). Marital Status is included in each of the models as a series of dummy variables where those who indicated they were Single (and Not Cohabitating) serve as the reference category. Using imputation by chained equations I imputed values for respondents with missing data (described below).

Marital Change: For Chapter 5 I created a marital change variable to reflect changes in women's marriage status at Times 2 and 3. Because marriage appears to have the largest effects on women's access to various forms of insurance, only transitions into and out of marriage are considered. Possible response categories include: those who Stayed Unmarried from Wave 1 to Wave 2 (or Wave 2 to Wave 3), those who Left a Marriage, those who Got Married, and those who Stayed Married. Marital Change is included in each of the models as a series of dummy variables where those who Stayed Unmarried from Wave 1 to Wave 2 (or Wave 2 to Wave 3) serve as the reference category.

Marriage Trajectory: For Chapter 6 I created a trajectory variable to reflect changes in women's marital status over the three data collection time points. Although a total of 61 unique trajectories were observed, categories were grouped to reflect seven basic trajectories determined by women's marital status at Wave 3: those who were Continuously Single (Not Cohabiting) across all three time points, those who Became Single by Wave 3, those who Started or Stayed Cohabiting, those Continuously Married across all three time points, those who Got Married by Wave 3, those Continuously Separated (Spouse Not Present), and those who Moved Into Separation by Wave 3. Marriage Trajectory is included in each of the models as a series of dummy variables where those who were Continuously Single (Not Cohabiting) across all three time points serve as the reference category.

Health Independent Variables

One's health status may shape both their need for insurance as well as their access to various insurance programs. Several measures are used to assess respondents' health needs and medical care access.

Health: Respondents were asked to rate their general health. I recoded the original variable to reflect three simplified categories: those who indicated that their general health was Excellent or Very Good, those who indicated Good, and those who said their health was Fair or Poor. Health is included in each of the models as a series of dummy variables where those who indicated that their general health was Excellent or Very Good serve as the reference category.

Health Problem: Respondents were asked if any health problems they experienced affected their ability to work. Those who indicated No serve as the reference category and are coded as 0, while those who indicated Yes, health problems prevented them from working are coded as 1.

Health Need: Respondents were asked if over the previous 12 months they ever needed but could not afford necessary care. Those who indicated No serve as the reference category and are coded as 0, while those who indicated Yes, they needed but could not afford need care were coded as 1.

Uninsured: In Chapter 4 insurance status is measured as a dichotomous variable. Those who had some form of insurance are coded as 0, and those who were Uninsured are coded as 1.

Public HI: In Chapter 4 public health insurance status is measured as a dichotomous variable. Those who were not on Medicaid are coded as 0, and those who were on Medicaid are coded as 1.

Private/Employer HI: In Chapter 4 private or employer health insurance status is measured as a dichotomous variable. Those who did not have private or employer health insurance are coded as 0, and those who did have private or employer health insurance are coded as 1.

Insurance Change: For Chapter 5 I created a variable to measure changes in women's uninsured status at Times 2 and 3. Possible categories include: those who Stayed Insured from Wave 1 to Wave 2 (or Wave 2 to Wave 3), those who Got Insurance, those who were previously insured but Lost Insurance, and those who Stayed Uninsured. Insurance Change is included in each of the models as a series of dummy variables where those who Stayed Insured from Wave 1 to Wave 2 (or Wave 2 to Wave 3) serve as the reference category.

Public HI Change: For Chapter 5 I also created a variable to measure changes in women's public health insurance access at Times 2 and 3. Possible categories include: those who Stayed Off Public HI from Wave 1 to Wave 2 (or Wave 2 to Wave 3), those who Got Off Public HI, those who Got On Public HI, and those who Stayed On Public HI. Public HI Change is included in each of the models as a series of dummy variables

where those who Stayed Off Public HI from Wave 1 to Wave 2 (or Wave 2 to Wave 3) serve as the reference category.

Private/Employer HI Change: Again, for Chapter 5, I created a variable to measure changes in women's access to private or employer health insurance at Times 2 and 3. Possible categories include: those who Stayed Off Private/Employer HI from Wave 1 to Wave 2 (or Wave 2 to Wave 3), those who Lost Private/Employer HI, those who Got Private/Employer HI, and those who Kept Private/Employer HI. Private/Employer HI Change is included in each of the models as a series of dummy variables where those who Stayed Off Private/Employer HI from Wave 1 to Wave 2 (or Wave 2 to Wave 3) serve as the reference category.

Insurance Trajectory: For Chapter 6 I created a trajectory variable to reflect changes in women's health insurance status over the three data collection time points. Although a total of 27 unique trajectories were observed, categories were grouped to reflect 6 basic trajectories: those who were Continuously Uninsured across all three waves, those who Became Uninsured by Wave 3, those who were Continuously on Public HI, those who Moved Into Public HI by Wave 3, those who were Continuously on Private/Employer HI across all three time points, and those who Moved Into Private/Employer HI by Wave 3. Insurance Trajectory is included in each of the models as a series of dummy variables where those who were Continuously Uninsured across all three waves serve as the reference category.

Control Variables

Several important control variables are also included in the models where appropriate.

Time: In both the Chapter 4 lagged effects models and the Chapter 5 change variable models, data collection time point identifiers are used to control for historical moment. This variable indicates which survey (Wave 1, Wave 2, or Wave 3) independent variables are being drawn from.

Months: A ratio level Months variable is also used in all models to control for amount of time between data collection time points and is measured in total number of months.

City: City of residence (Boston, Chicago, and San Antonio) is included in the models as a series of dummy variables where Boston serves as the reference category.

Citizenship: Respondents were asked to indicate whether they were US-born, US territory-born, or Foreign-born. Those who indicated they were foreign-born were then asked to indicate if they were a US citizen. Citizens (both foreign-born and US-born) are coded as 1 and non-citizens are coded as 0. Using imputation by chained equations I imputed values for respondents with missing data (described below).

Race/Ethnicity: Self-reported race/ethnicity is measured as a categorical variable with four options: white (Non-Hispanic), Black (Non-Hispanic), Hispanic, and "Other." Race/Ethnicity is included in the models as a series of dummy variables where whites serve as the reference category.

Age: Age is a ratio level variable measured in years.

Kids: Also measured as a ratio level variable, respondents were asked to identify the number of children in their household that they were legally responsible for at each wave.

Imputation of Missing Values

Although the problem of missing data is common in large studies, ignoring missing data can result in biased estimates and reduced statistical power (Acock 2005). In order to assess the implications of missing data for my research, I performed a series of analyses examining differences between respondents with complete and missing data. The findings (not shown) suggest that losing cases in my analyses to listwise deletion may result in underrepresentation of non-citizen minorities and individuals with low levels of education and income. Fortunately, advanced statistical techniques have been developed for dealing with missing data. In order to prevent the loss of cases to listwise deletion, I used Stata's Imputation by Chained Equations (ICE) program to impute missing values on four key demographic variables: income, citizenship, education, and marital status.

A total of 149 values were imputed for missing data on citizenship (2 at W1, 74 at W2, and 73 at W3), 848 values were imputed for missing data on income (448 at W1, 220 at W2, 180 at W3), 76 values were imputed for missing data on marital status (4 at W1, 25 at W2, 47 at W3), and 186 values were imputed for missing data on education (3 at W1, 57 at W2, 126 at W3). Thirty-four percent (572) of the sample required imputation on one variable, 13 percent (223) required imputation on two variables, three percent (54) required imputation on three variables,

and one percent (17) required imputation on all four of the variables for which imputation of missing values was conducted.

Using available data for all other variables included in the models, ICE uses the most appropriate estimation method based on each variable's level of measurement (regression, logistic regression, or multinomial regression) to predict the missing values for each case (StataCorp 2007). The program also "injects a degree of random error to reflect uncertainty of imputation" (Acock 2005: 1018). Although multiple imputation, which generates several imputed datasets and then pools the results to account for missing data uncertainty, provides superior estimates to a single imputation approach and unbiased standard errors, single imputation is preferable over mean substitution and acceptable for producing preliminary analyses when dealing with many different models (Acock 2005).

Descriptive Statistics

See Tables 3.2, 3.3, and 3.4 for a summary of descriptive statistics. Eight percent of the families were white, 42 percent Black, and 48 percent Hispanic. The number of white respondents is not proportional to the number of Black and Hispanic respondents due to a lack of high-poverty white neighborhoods. Nevertheless, the study is generalizable to low-income families living in low-income neighborhoods in Boston, Chicago, and San Antonio (ICPSR 2008). Overall, about 35 percent of the sample was from Boston, 33 percent from Chicago, and 32 percent from San Antonio. At Wave 1 about 86 percent of respondents indicated they were U.S. citizens. The average age of respondents at Wave 1 was 32.8 years and about 38 percent had no high school degree or GED while only six percent had a college degree. The average number of children women were responsible for was about 2.7 across all three time points.

Table 3.2 Descriptive Statistics for Demographic Variables by Wave (N=1662)

		Wave 1 (1999)	Wave 2 (2001)	Wave 3 (2005)
City	Boston	35.1% (584)		
	Chicago	33.2% (551)		
	San Antonio	31.7% (527)		
Race	Black	42.4% (705)		
	Hispanic	47.7% (793)		
	White	8.0% (133)		
	Other	1.9% (31)		
Not US Citizen, Imputed		14.4% (239)	13.2% (220)	12.2% (202)
Mean Age (Std. Deviation)		32.76 (9.68)	34.12 (9.64)	38.54 (9.65)
Marital Status, Imputed	Single	68.2% (1134)	56.4% (938)	55.1% (916)
	Cohabiting	6.4% (106)	10.8% (179)	9.5% (158)
	Separated	11.4% (190)	15.6% (260)	15.8% (263)
	Married	14.0% (232)	17.1% (285)	19.6% (325)
Mean Kids Responsible For (Std. Dev)		2.66 (1.43)	2.69 (1.45)	2.77 (1.52)
Education, Imputed	No Degree	37.8% (629)	39.9% (664)	35.4% (589)
	HS Grad/GED	56.1% (933)	52.9% (879)	55.0% (914)
	College	6.0% (100)	7.2% (119)	9.6% (159)
Mean Monthly Total Household Income, Imputed (Std. Deviation)		1,089.85 (814.21)	1,567.39 (1107.70)	1,846.38 (1353.07)
Total Household Income 100-200% FPL		22.6% (376)	30.7% (510)	34.4% (572)
Total Household Income Below 100% FPL		73.3% (1218)	59.6% (990)	53.2% (884)
On Welfare (Enrolled in TANF)		36.7% (610)	25.8% (429)	14.6% (243)
Employment	Employed	40.0% (658)	55.8% (927)	54.6% (908)
	Employed 35+ Hrs at Main Job	22.8% (379)	36.0% (599)	33.7% (560)
Respondent HI	Medicaid	53.0% (881)	49.3% (819)	48.9% (812)
	Private or Employer HI	15.5% (257)	20.2% (336)	21.0% (349)
	Uninsured	30.0% (499)	28.7% (477)	27.9% (464)
General Health	Excellent/Very Good	38.9% (646)	38.0% (631)	32.9% (546)
	Good	31.5% (523)	33.6% (559)	32.8% (545)
	Fair/Poor	29.6% (492)	28.1% (467)	34.2% (568)
Health Problems Prevent Working		14.5% (241)	16.2% (270)	22.5% (374)
Needed but Could Not Afford Care		12.9% (215)	12.9% (215)	15.7% (261)

The summary statistics provided in Table 3.2 also reveal that the women experienced a great deal of aggregate level change over the six year study period. For example, the proportion of women with incomes below the federal poverty line decreased 20 percent (from 73 percent at Wave 1, to 53 percent at Wave 3). A comparable reduction in welfare recipients was also observed; at Wave 1, 36.7 percent of the women were receiving TANF benefits, but by Wave 3 only 14.6 percent of the panel was on welfare. Consistent with the goals of welfare reform, the proportion of women gainfully employed increased almost 15 percent (from 40 percent at Wave 1, to 54.6 percent at Wave 3). The proportion of women working full-time (35 hours or more) increased about 11 percent (from 22.8 percent at Wave 1, to 33.7 percent at Wave 3). Also consistent with welfare reform, the proportion of women married increased from 14 percent at Wave 1 to 19.6 percent at Wave 3. Nevertheless, the number of women experiencing separation from a spouse also increased from 11.4 percent at Wave 1 to 15.8 percent at Wave 3. These trends are consistent with other research examining the effects of welfare reform on low-income women.

Despite the increase in women's labor force participation and marriage, overall trends in health insurance status were far less substantial. For example, the proportion of women who were uninsured decreased only slightly from 30 percent at Wave 1 to about 28 percent at Wave 3, whereas the proportion of women who had private or employer-provided health insurance increased 5.5 percent (from 15.5 percent at Wave 1, to 21 percent at Wave 3). Consistent with the existing literature on welfare reform, the proportion of women receiving Medicaid decreased 4.1 percent over the study period (from 53 percent at Wave 1, to 48.9 percent at Wave 3). In addition, the proportion of women who self-rated their health as excellent or very good decreased from 38.9 percent at Wave 1 to 32.9 percent at Wave 3, while the proportion of

women reporting fair or poor health increased from 29.6 percent to 34.2 percent over the study period. Similarly, the proportion of women reporting that they needed but could not afford care increased by about 2.8 percent, while the proportion of women reporting that health problems prevented them from working increased eight percent to a total of 22.5 percent at Wave 3.

Although interesting, these overall trends mask important *individual level* changes that were occurring (see Table 3.3). When we examine the proportion of women who experienced change in any of the aforementioned statuses, we begin to learn more about the dynamic work, family, and welfare patterns of this population. For example, from Wave 1 to Wave 2, 13.6 percent of the women moved into full-time work (35 hours or more), while only 2.9 percent lost access to full-time work. But from Wave 2 to Wave 3, only 7.3 percent of the women moved into full-time work, while 6.9 percent lost full-time status, revealing much more variability in employment opportunities over the data collection period. A similar trend was observed in marriage transitions. From Wave 1 to Wave 2, 6.6 percent of the women moved into marriage while 3.4 percent left a marriage. But from Wave 2 to Wave 3, 9.3 percent of women moved into a marriage while 6.9 percent left a marriage. Changes in women's poverty status were just as dynamic. While 24.7 percent of women moved out of poverty from Wave 1 to Wave 2, 11 percent of women moved into poverty during this same period. From Wave 2 to Wave 3, 15.7 percent of the women moved into poverty, while 22.1 percent moved out of poverty. In addition, over both time periods more women moved out of Medicaid than into Medicaid, while more women moved into private or employment based health insurance than out of such insurance.

Table 3.3 Descriptive Statistics for Change Variables by Wave (N=1662)

		Wave 2	Wave 3
Mean Months Between Time Points (Std. Dev.)		16.34 (2.8)	53.10 (3.1)
Poverty Status Change	Stayed in Poverty	48.6% (808)	37.5% (623)
	Into Poverty	11.0% (182)	15.7% (261)
	Out of Poverty	24.7% (410)	22.1% (367)
	Stayed above Poverty	15.8% (262)	24.7% (411)
Marital Status Change	Stayed Unmarried	79.4% (1320)	73.6% (1223)
	Out of Marriage	3.4% (57)	6.9% (114)
	Into Marriage	6.6% (110)	9.3% (154)
	Stayed Married	10.5% (175)	10.3% (171)
FT Employment Change	Stayed < Employed FT	67.3% (1119)	64.5% (1072)
	Out of FT Work	2.9% (49)	6.9% (114)
	Into FT Work	13.6% (226)	7.3% (122)
	Stayed Employed FT	16.1% (268)	21.2% (353)
Welfare Change	Stayed On Welfare	19.7% (328)	8.0% (133)
	Into Welfare	6.1% (101)	6.5% (108)
	Out of Welfare	16.9% (281)	17.7% (295)
	Stayed Off Welfare	56.7% (942)	67.2% (1117)
Insurance Transition	Stayed Uninsured	15.5% (257)	14.5% (241)
	Out of Insurance	13.2% (219)	13.4% (223)
	Into Insurance	14.6% (242)	14.1% (235)
	Stayed Insured	56.4% (937)	57.5% (955)
Public Insurance Transition	Stayed on Medicaid	38.7% (643)	36.3% (604)
	Into Medicaid	10.6% (176)	12.5% (208)
	Out of Medicaid	14.3% (238)	12.9% (215)
	Stayed Off Medicaid	36.4% (605)	38.2% (635)
Private/Employer HI Transition	Stayed Out of Private/Employer HI	75.6% (1256)	70.6% (1173)
	Out of Priv/Employ HI	4.2% (70)	8.4% (140)
	Into Priv/Employ HI	9.0% (149)	9.2% (153)
	Stayed On Priv/Emp HI	11.3% (187)	11.8% (196)

In other areas, change across the two time intervals was more stable. For example, just over 6 percent of the sample moved on to welfare from Wave 1 to Wave 2, and a comparable proportion moved on to welfare from Wave 2 to Wave 3. Similarly, the proportion of women moving off of welfare remained at about 17 percent during both intervals. Consistent patterns of change in insurance coverage were also observed between time points; about 14 percent of the women gained insurance over both time periods, while 13 percent of women lost insurance coverage over both intervals.

The amount of change these women experienced illustrates the need to consider how patterns of change across the three time points might affect women's access to health insurance and economic well-being over time. By generating measures of subsequent work, welfare, and marital transitions, trajectory variables may best represent the dynamic nature of low-income women's lives. Using measures of work, welfare, and marital status at Wave 1, Wave 2, and Wave 3, trajectory variables were created that describe the unique patterns of statuses for each respondent across the three time points. Although notable patterns emerged for each variable, there were also many unique patterns that emerged. Table 3.4 shows the number of respondents in each trajectory category and also provides examples of unique patterns within each category to illustrate how trajectories were grouped.[6] These trajectories reveal important patterns over the study period. For example, while over 26 percent of the sample remained continuously unemployed, only 6.4 percent were continuously on welfare at all three data collection time points. While nearly 41 percent of the sample was continuously single (not cohabiting), only 7.2 percent were continuously married. In terms of health insurance access, only a relatively small proportion of women were continuously uninsured (9.2 percent) or on private/employer based

[6] All change and trajectory measures represent differences in statuses from the previous data collection time point. Measures of transitions between Waves were not collected for most variables. Thus, both the change and trajectory measures represent conservative estimates of the changes these women may have experienced.

health insurance (8.1 percent) at all three time points, while there was greater stability in access to public health insurance; 29.3 percent of women were continuously on public health insurance across all three time points. Fewer women also slipped into poverty than moved out of poverty over time; while 35.7 percent of the women moved out of poverty by Wave 3, 21.5 percent actually slipped into poverty by Wave 3.

Table 3.4 Descriptive Statistics for Trajectory Variables (N=1662)

Trajectory	Sample Patterns*	Percent (n)
Employment		
Continuously Unemployed	U-U-U	26.4% (438)
Became Unemployed	F-F-U, F-U-U, L-U-U, L-L-U	19.0% (315)
Stayed or Moved into PT Work	L-L-L, U-U-L, U-L-L, U-F-L	20.9% (348)
Continuously Employed FT	F-F-F	11.2% (186)
Moved into FT Work	U-F-F, U-U-F, L-F-F, U-L-F	22.5% (374)
Welfare Status		
Continuously Off Welfare	O-O-O	52.2% (868)
Moved Off Welfare	W-O-O, W-W-O, O-W-O	32.6% (541)
Continuously On Welfare	W-W-W	6.4% (107)
Moved Onto Welfare	O-O-W, O-W-W, W-O-W	8.0% (133)
Marriage		
Continuously Single	S-S-S	40.7% (676)
Became Single	S-C-S, C-S-S, S-D-S, D-D-S	14.4% (240)
Became or Stayed Cohabiting	C-C-C, S-S-C, S-C-C	9.5% (158)
Continuously Married	M-M-M	7.2% (120)
Got Married	S-S-M, S-M-M, S-C-M, C-C-M	12.3% (205)
Continuously Separated	D-D-D	4.0% (66)
Became Separated	M-M-D, S-M-D, S-S-D, S-D-D	11.9% (197)
Health Insurance		
Continuously Uninsured	U-U-U	9.2% (153)
Became Uninsured	P-P-U, P-U-U, E-E-U, E-U-U	17.0% (283)
Continuously on Public HI	P-P-P	29.3% (487)
Got on Public HI	U-P-P, U-U-P, U-E-P, E-E-P	18.9% (314)
Continuous Private/Employer HI	E-E-E	8.1% (135)
Got on Private/Employer HI	P-P-E, P-E-E, U-U-E, U-E-E	12.5% (207)
Poverty		
Continuously Out of Poverty	OP-OP-OP	11.1% (185)
Got Out of Poverty	IP-OP-OP, IP-IP-OP	35.7% (593)
Continuously In Poverty	IP-IP-IP	31.6% (526)
Slipped Into Poverty	OP-OP-IP, OP-IP-IP	21.5% (358)

*Note: F=Employed Full-time (35+ hours), L=Employed Less than Full-time, U=Unemployed, W=On Welfare, O=Off Welfare, M=Married, S=Single (Not Cohabiting), C=Cohabiting, D=Separated or Spouse not Present, U=Uninsured, E=Private/Employer Health Insurance, P=Public Health Insurance, OP=Out of Poverty, IP=In Poverty

Methods

A practical benefit of analyzing panel data is that it allows us to observe change over time. In each model the dependent variable is categorical, violating simple linear regression assumptions regarding the homoscadasticity of error terms, and necessitating use of a logistic regression approach (Long and Freese 2006). Given the benefits of panel data and the categorical nature of my dependent variables, I use Stata 10 (StataCorp 2007) to run a series of logistic regression models that will be used to assess how women's welfare, employment, and family statuses affect their health insurance status and poverty status.

In the first set of analyses, presented in Chapter 4, I examine the lagged effects of Time 1 measures on women's opportunities at Time 2. In these analyses the data are "stacked," meaning each respondent is represented twice in the dataset. Stacking the data allows me to test simultaneously how factors at Wave 1 are related to statuses at Wave 2 and how factors at Wave 2 are related to statuses at Wave 3. Organizing the data in this way allows the independent variables to be Wave 1 or Wave 2 data and the dependent variables to be Wave 2 or Wave 3 data. For ease of reference and clarity, in the lagged effects analysis models the abbreviation T1 is used to represent data collected at Wave 1 or Wave 2, while T2 is used to represent data collected at Wave 2 or Wave 3. As described above, stacking the data increases the total number of observations by representing each respondent twice in the dataset. To control for this, the lagged effects analyses are clustered by respondent. Controls for which time point the data are drawn and the length of time in between data collection time points are also included.

In Chapter 5 I test the effects of several measures of change on women's insurance and poverty status. Like Chapter 4, the data remain stacked to allow me to test the effects of changes from Waves 1 to 2, and 2 to 3 simultaneously. But unlike Chapter 4, I do not test for lagged

effects. Instead, all control variables in Chapter 5 are measured at T2 while the new welfare, work, family, and insurance change variables included in the models measure changes from either Wave 1 to 2, or Wave 2 to 3. Because the data remain stacked for these analyses, cluster, time point, and months lapsed controls are still included in these models. In the trajectory models presented in Chapter 6, the data are not stacked, reducing the total number of observations and eliminating the need for cluster and time controls in these models. Nevertheless, lapse controls are still included in the trajectory models to control for the amount of time between waves since the longer the time between surveys, the more likely a woman is to experience change in her welfare, work, or family status. Normalized household panel weights are used in all models to prevent bias in point estimates (Cherlin, Fomby, and Moffitt 2002).

In all models the dependent variables of interest are measured dichotomously. Using standard binary logistic regression models will allow me to predict the odds of women's insurance coverage and poverty status at Time 2 or 3 (depending on the model) controlling for their welfare, work, and family status at earlier time points. The results of the logistic regression models will provide estimates of the probability of being uninsured, being on Medicaid, or having private/employer insurance for one group of individuals compared to a comparison group at the specified time point (or the probability of being in poverty for one group of individuals compared to a comparison group) controlling for the effects of individual welfare, work, and family factors at Wave 1, Wave 2, and Wave 3.

The logistic regression model is represented by the following equation:

$$P(Y = 1) = [\ \exp(\alpha + \beta_1 X_1 + \beta_2 X_2 \ldots + \beta_K X_K) / (1 + \exp(\alpha + \beta_1 X_1 + \beta_2 X_2 \ldots + \beta_K X_K))\ ],$$

where Y represents the dependent variable, α represents the intercept, $X_{1\ldots K}$ represent the independent variables, and $\beta_{1\ldots K}$ represent "the marginal effect of the corresponding X_K" on the

log-odds of Y (Liao 1994:8). Exponentiating each β_K to produce odds-ratios provides a more intuitive interpretation of the model estimates; exp(β) can be interpreted as "the odds of having an event occurring versus not occurring, per unit change in the explanatory variable, other things being equal" (Liao 1994:16).

With the exception of the ratio level variables (e.g., Kids, Age, Income, and Months), in the following analyses all other independent variables are treated as dummy variables composed of two categories (e.g., US Citizen versus non-US Citizen). Where variables have more than one response category, each category is treated as a separate dummy variable comparing the specified group to a reference category (e.g., Black versus White, Hispanic versus White). Reference categories are identified in parentheses in the results tables. Thus, "a unit change" in these variables represents changing from one category to the other. So, for example, in Models 1-9, 12-23, and 30-41 (see Tables 3.5a-c) the estimates produced can be interpreted as the odds of one group having the specified type of insurance compared to the reference category, controlling for the other variables in the model. In models 10-11, 24-29, and 42-43 the estimates can be interpreted as the odds of one group moving into or out of poverty compared to the reference category, controlling for the other variables in the model. In the results tables I present the odds-ratios and 95 percent confidence intervals for each variable included in the models.

Analysis

Tables 3.5a-c outline the sequence of models that will be analyzed in order to answer my research questions. Models 1-3, 12-17, and 30-35 address the first major research question: what is the relative importance of various welfare, work, and family factors in predicting low-income women's health insurance status over time? Whereas Chapter 4 Models 1-3 examine the lagged

effects of independent variables on health insurance access at later times, Chapter 5 Models 12-17 and Chapter 6 Models 30-35 examine how using measures of change and trajectory might improve our understanding of women's health insurance access. In Model 1, the dependent variable will be women's general insurance status, a measure indicating whether respondents have insurance or are uninsured at T2. In Model 2, the dependent variable will be whether respondents are on public insurance at T2. In Model 3, the dependent variable will be whether respondents have private/employer based insurance at T2. In these models, the independent variables will include T1 measures for welfare, family, and work factors, including use of TANF, full-time employment, education, total household income, marital status, and control variables such as data collection time point, months between interviews, race/ethnicity, citizenship, number of children responsible for, and city of residence. Several health measures are also included, such as respondents' self rated general health status, whether health problems affect their ability to work, and a measure indicating if they needed care in the past year but were unable to afford it.

In Chapter 5, Models 12-17 replicate this process by comparing static models (Models 12, 14, and 16) with models using change measures (Models 13, 15, and 17) in order to determine if using change measures helps to better explain women's access to certain forms of insurance or poverty status. Unlike Chapter 4, the control variables used in the Chapter 5 models are measured at T2 since the change measures reflect women's T2 statuses. Similarly, in Chapter 6, Models 30-35 also replicate this process by comparing cross-sectional models (Models 30, 32, and 34) with trajectory models (Models 31, 33, and 35). In these models the control variables are measured at Wave 3.

Models 4-9, 18-23, and 36-41 address the second major research question: are there significant differences between low-income women, specifically poor and near-poor women, in the importance of welfare, work, and family factors in determining women's health insurance status over time? As described above, the category of low-income women (often defined as those with household incomes less than 200 percent of the Federal Poverty Level) is frequently treated as a homogenous category of economically marginalized women for descriptive purposes. Despite similar social and economic struggles, previous research reveals significant differences in the extent of their vulnerabilities and access to supports and services based on their poverty status. For example, even small income changes influence women's access to certain social services. Thus, it is important to determine if the effects of the aforementioned welfare, family, and work factors vary among groups of low-income women.

Table 3.5a Chapter 4 Lagged Effects Analysis Model Summaries

Question & Model		Variables
What is the relative importance of various T1 welfare, work, and family factors in predicting low-income women's health insurance status at T2?		
Model 1	Dependent	Uninsured (T2)
	Independent	Time (T1) Months (T2) City (reference category Boston) Race/Ethnicity (reference category White) Citizenship (T1, reference category Non-Citizen) Kids (T1) Age (T1) Education (T1, reference category No Degree) FT Work (T1, reference category Unemployed) Income (T1) Welfare Status (T1, reference category Not On Welfare) Marital Status (T1, reference category Single, not cohabiting) Health (T1, reference category Excellent) Health Problem (T1, reference category No) Health Need (T1, reference category No)
Model 2	Dependent	Public HI (T2)
	Independent	*Same as Model 1*
Model 3	Dependent:	Private/Employer HI (T2)
	Independent	*Same as Model 1*
Are there significant differences between poor and near-poor women in the lagged effects of T1 welfare, work, and family factors on their health insurance access at T2?		
Model 4	*Same as Model 1, selected for the Near-poor (T1)*	
Model 5	*Same as Model 1, selected for the Poor (T1)*	
Model 6	*Same as Model 2, selected for the Near-poor (T1)*	
Model 7	*Same as Model 2, selected for the Poor (T1)*	
Model 8	*Same as Model 3, selected for the Near-poor (T1)*	
Model 9	*Same as Model 3, selected for the Poor (T1)*	
Given the lagged effects of welfare, work, and family factors on low-income women's health insurance access at T2, what role does health insurance access play in determining women's poverty status over time?		
Model 10	Dependent	Poverty Status Change (T2) – Selected for those who were not poor at Wave 1 (represents movement into poverty by T2)
	Independent	*Same as Model 1, except add* Insurance (T1, reference category Uninsured)
Model 11	Dependent	Poverty Status Change (T2) – Selected for those who were poor at Wave 1 (represents movement out of poverty by T2)
	Independent	*Same as Model 1, except add* Insurance (T1, reference category Uninsured)

Table 3.5b Chapter 5 Change Variable Model Summaries

Question & Model		Variables
What is the relative importance of various welfare, work, and family changes in predicting low-income women's health insurance status over time?		
Model 12	Dependent	Uninsured (T2)
	Controls	Time (T2)
		Months (T-2)
		City (reference category Boston)
		Race/Ethnicity (reference category White)
		Citizenship (T2, reference category Non-Citizen)
		Kids (T2)
		Age (T2)
		Education (T2, reference category No Degree)
		Income (T2)
		Health (T2, reference category Excellent)
		Health Problem (T2, reference category No)
		Health Need (T2, reference category No)
	Independent	Welfare Status (T2, reference category Not On Welfare)
		Marital Status (T2, reference category Single, not cohabiting)
		FT Work (T2, reference category Unemployed)
Model 13	Dependent	Uninsured (T2)
	Controls	*Same as Model 12*
	Independent	Employment Change (T2 or T3, reference category Stayed < FT Employed)
		Welfare Change (T2 or T3, reference category Stayed Off Welfare)
		Marital Change (T2 or T3, reference category Stayed Single)
Model 14	Dependent	Public HI (T2)
	Independent	*Same as Model 12*
Model 15	Dependent	Public HI (T2)
	Independent	*Same as Model 13*
Model 16	Dependent	Private/Employer HI (T2)
	Independent	*Same as Model 12*
Model 17	Dependent	Private/Employer HI (T2)
	Independent	*Same as Model 13*
Are there significant differences between poor and near-poor women in the effects of welfare, work, and family changes on their health insurance access over time?		
Model 18	*Same as Model 13, selected for the Near-poor (T1)*	
Model 19	*Same as Model 13, selected for the Poor (T1)*	
Model 20	*Same as Model 15, selected for the Near-poor (T1)*	
Model 21	*Same as Model 15, selected for the Poor (T1)*	
Model 22	*Same as Model 17, selected for the Near-poor (T1)*	
Model 23	*Same as Model 17, selected for the Poor (T1)*	

Table 3.5b Chapter 5 Change Variable Model Summaries, *continued*

Question & Model		Variables
Given the effects of welfare, work, and family changes on low-income women's health insurance access, what role do health insurance changes play in determining women's poverty status over time?		
Model 24	Dependent	Poverty Status Change (T2) – Selected for those who were not poor at Wave 1 (represents movement into poverty by T2)
	Controls	Time (T2) Months (T2) City (reference category Boston) Race/Ethnicity (reference category White) Citizenship (T2, reference category Non-Citizen) Kids (T2) Age (T2) Education (T2, reference category No Degree) Health (T2, reference category Excellent) Health Problem (T2, reference category No) Health Need (T2, reference category No) Employment Change (T2 or 3, reference category Stayed Less Than Full-time Employed) Welfare Change (T2 or 3, reference category Stayed Off Welfare) Marital Change (T2 or 3, reference category Stayed Single)
	Independent	Insurance Change (T2 or T3, reference category Stayed Insured)
Model 25	Dependent	Poverty Status Change (T2) – Selected for those who were poor at Wave 1 (represents movement out of poverty by T2)
	Independent	*Same as Model 24, Plus Controls*
Model 26	Dependent	Poverty Status Change (T2) – Selected for those who were not poor at Wave 1 (represents movement into poverty by T2)
	Independent	Public HI Change (T2 or T3, reference category Stayed Off Public HI), *Plus Model 24 Controls*
Model 27	Dependent	Poverty Status Change (T2) – Selected for those who were poor at Wave 1 (represents movement out of poverty by T2)
	Independent	*Same as Model 26*
Model 28	Dependent	Poverty Status Change (T2) – Selected for those who were not poor at Wave 1 (represents movement into poverty by T2)
	Independent	Private/Employer HI Change (T2 or T3, reference category Stayed Off Private/Employer HI), *Plus Model 24 Controls*
Model 29	Dependent	Poverty Status Change (T2) – Selected for those who were poor at Wave 1 (represents movement out of poverty by T2)
	Independent	*Same as Model 28*

Table 3.5c Chapter 6 Trajectory Model Summaries

Question & Model		Variables
What is the relative importance of various welfare, work, and family trajectories in predicting low-income women's health insurance status over time?		
Model 30	Dependent	Uninsured (Wave 3)
	Independent	FT Work (Wave 3, reference category FT Employed)
		Welfare Status (Wave 3, reference category Not On Welfare)
		Marital Status (Wave 3, reference category Married, spouse present)
	Controls	Months 2 (Wave 2)
		Months 3 (Wave 3)
		City (reference category Boston)
		Race/Ethnicity (reference category White)
		Citizenship (Wave 3, reference category Non-Citizen)
		Kids (Wave 3)
		Age (Wave 3)
		Education (Wave 3, reference category No Degree)
		Income (Wave 3)
		Health (Wave 3, reference category Excellent)
		Health Problem (Wave 3, reference category No)
		Health Need (Wave 3, reference category No)
Model 31	Dependent	Uninsured (Wave 3)
	Independent	Employment Trajectory (reference category Continuously Employed FT)
		Welfare Trajectory (reference category Continuously Off Welfare)
		Marriage Trajectory (reference category Continuously Married)
		Plus Model 30 Controls
Model 32	Dependent	Public HI (Wave 3)
	Independent	*Same as Model 30 (Cross-sectional Variables)*
Model 33	Dependent	Public HI (Wave 3)
	Independent	*Same as Model 31 (Trajectory Variables)*
Model 34	Dependent	Private/Employer HI (Wave 3)
	Independent	*Same as Model 30 (Cross-sectional Variables)*
Model 35	Dependent	Private/Employer HI (Wave 3)
	Independent	*Same as Model 31 (Trajectory Variables)*
Are there significant differences between poor and near-poor women in the effects of welfare, work, and family factors on their health insurance access over time?		
Model 36	*Same as Model 31, selected for the Near-poor (Wave 1)*	
Model 37	*Same as Model 31, selected for the Poor (Wave 1)*	
Model 38	*Same as Model 33, selected for the Near-poor (Wave 1)*	
Model 39	*Same as Model 33, selected for the Poor (Wave 1)*	
Model 40	*Same as Model 35, selected for the Near-poor (Wave 1)*	
Model 41	*Same as Model 35, selected for the Poor (Wave 1)*	

Table 3.5c Chapter 6 Trajectory Model Summaries, *continued*

Question & Model		Variables
Given the effects of welfare, work, and family trajectories on low-income women's health insurance access, what role do health insurance trajectories play in determining women's poverty status over time?		
Model 42	Dependent	Poverty Status Change (Wave 3) – Selected for those who were not poor at Wave 1 (represents movement into poverty by Wave 3)
	Independent	Months 2 (Wave 2) Months 3 (Wave 3) City (reference category Boston) Race/Ethnicity (reference category White) Citizenship (Wave 3, reference category Non-Citizen) Kids (Wave 3) Age (Wave 3) Education (Wave 3, reference category No Degree) Health (Wave 3, reference category Excellent) Health Problem (Wave 3, reference category No) Health Need (Wave 3, reference category No) Employment Trajectory (reference category Continuously Employed FT) Welfare Trajectory (reference category Continuously Off Welfare) Marriage Trajectory (reference category Continuously Married) Insurance Trajectory (reference category Continuous Private/Employer HI)
Model 43	Dependent	Poverty Status Change (Wave 3) – Selected for those who were poor at Wave 1 (represents movement out of poverty by Wave 3)
	Independent	*Same as Model 42*

In order to examine differences in the lagged effects of women's work, welfare, and family statuses between poor women (those with total household incomes less than or equal to 100 percent FPL) and near-poor women (those with total household incomes greater than 100% FPL), in Chapter 4 Models 4-9 I rerun the previous models using separate models by women's poverty status at T1. Models 4, 6, and 8 test the lagged effects of the independent variables for near-poor women, whereas Models 5, 7, and 9 test the lagged effects of the same variables for poor women. A similar process is replicated in Chapter 5, where I run separate analysis utilizing change variables by women's poverty status at T1. Models 18, 20, and 22 test the effects of change variables for near-poor women, while Models 19, 21, and 23 test the effects of these same variables for poor women. Again, in Chapter 6, I run separate analyses utilizing change variables by women's poverty status at T1. Models 36, 38, and 40 test the effects of trajectory variables for near-poor women, whereas Models 37, 39, and 41 test the effects of the same variables for poor women. Postestimation nonlinear Wald tests will also be performed to test the hypothesis that individual coefficients are equal across the poor and near-poor models.

Finally, Models 10-11, 24-29, and 42-43 address the third question: given the effects of welfare, work, and family factors on low-income women's health insurance access, what role does health insurance access play in determining changes in women's poverty status over time? In Chapter 4, Models 10-11, the dependent variables will be whether women experience a change in poverty status at T2 (0 represents no change, 1 represents a change in poverty status). Model 10 selects for women who were near-poor at T1. Since the dependent variable in this model is whether a respondent experienced a change in poverty status at T2 (or not) this model tests the factors that are related to women's *movement into poverty* at T2. Model 11 selects for women who were poor at T1. Once again, since the dependent variable in this model is whether a

respondent experienced a change in poverty status at T2 (or not) this model tests the factors that are related to women's *movement out of poverty* at T2. The independent variables for these models will remain the same as the models described above, but I also include an additional measure of women's insurance coverage at T1 in order to test for the lagged effects of insurance access on women's economic status.

A similar process is repeated in Chapter 5, where I compare models that utilize change measures to predict women's *movement into poverty* at T2 (Models 24, 26, and 28) with models that utilize change measures to predict women's *movement out of poverty* at T2 (Models 25, 27, and 29). Finally, this process is repeated in Chapter 6, where I use a model containing trajectory measures to predict women's *movement into poverty* by W3 (Model 42) and a separate model to predict women's *movement out of poverty* by W3 (Model 43), in order to determine the utility of using a trajectory approach for our understanding of the effects of health insurance stability on women's economic status at Wave 3

CHAPTER FOUR

LAGGED EFFECTS ANALYSIS FINDINGS

In this Chapter I model the lagged effects of employment, welfare, and family variables on women's health insurance status over time. Utilizing longitudinal data in this way allows us to understand the long-term effects of a set of conditions on women's future opportunities. Using a series of logistic regression analyses we can determine how welfare, work, and family status at one time point affects low-income women's insurance access at later time points, if the lagged effects of welfare, work, and family factors vary for different groups of low-income women, and whether health insurance access at one time point affects low-income women's economic stability at later time points.

Research Question 1

What is the relative importance of individual-level welfare, work, and family factors in predicting low-income women's health insurance status over time?

Models 1-3 test the effects of welfare, work, and family factors on low-income women's health insurance access. Because there are different pathways to various forms of insurance, we might expect to observe differential effects for various factors by the type of health insurance being examined. Specifically, I expect to find that given the economic benefits of employment, full-time employment at T1 will have strong and consistent effects across models predicting women's insurance access at T2; full-time employment at earlier time points should reduce women's odds of being uninsured or publicly insured, and increase their odds of having access to

private or employment based insurance at later time points (H1a). In addition, I expect to find that although Medicaid was officially delinked from welfare in 1996, women on welfare at T1 are more likely to have public insurance and less likely to have private or employer based insurance at T2. Also, because of the protection public insurance provides to low-income women, I also expect to find that women on welfare at T1 may also be less likely to be uninsured at T2 (H1b). Finally, I expect to find that marriage at T1 will reduce women's odds of having access to public insurance and being uninsured, while increasing their odds of having access to private or employment based insurance at T2 (H1c).

Table 4.1 displays the results of the logistic regression analyses for Models 1-3. Model 1 uses women's insurance status (insured or uninsured) at T2 as the dependent variable. Model 2 uses women's public health insurance status at T2 as the dependent variable. And Model 3 uses women's private or employer health insurance status at T2 as the dependent variable. All independent variables are measured at T1. The table provides the odds ratios and 95 percent confidence intervals for each model. The reference categories for dummy variables with more than two response categories are indicated in parentheses. Odds ratios and level of significance are also provided in parentheses in the text where appropriate.

In Model 1, almost 17 percent of the variance in T2 insurance status is explained by the model, as indicated by the pseudo-R^2 value provided at the bottom of Table 4.1. In Models 2 and 3 the amount of variance explained increases dramatically; about 30 and 24 percent of the variance (respectively) is explained by the T1 welfare, work, family, and control variables included in the models.

As described below, the results also provide evidence that public programs like welfare and Medicaid provide important long-term protection against being uninsured or experiencing

unmet health needs at later time points. Nevertheless, careful examination reveals that the benefits of public programs may be limited to non-Hispanic citizens. As intended, younger women, those with children, and those with health problems appear to benefit most from access to public health insurance options. But what about women who do not qualify for public programs? The results of my analysis show that protective factors such as greater income may produce bifurcated long-term results among low-income women – although greater income may provide some women with access to private or employer based health insurance options, it also reduces their ability to qualify for public health insurance programs. Results also confirm that city differences play an important role in shaping the policy contexts which determine women's health insurance access.

Table 4.1 Logistic Regression Results for Lagged Effects on HI Status T2

	Uninsured Model1 (0=Has Insurance, 1=Uninsured)			Public HI Model 2 (0=No Medicaid, 1=On Medicaid)			Private/Employer HI Model 3 (0=No Priv/Employ HI, 1=Has HI)		
T1 Predictors	Odds Ratio	95% Conf Interval		Odds Ratio	95% Conf Interval		Odds Ratio	95% Conf Interval	
Time	1.424	0.207	9.793	0.396	0.066	2.390	1.525	0.166	14.045
Months	1.014	0.963	1.069	0.984	0.938	1.031	0.996	0.940	1.057
Race/Ethnicity (White)									
Black	1.551	0.603	3.991	0.902	0.524	1.554	0.867	0.353	2.128
Hispanic	2.770*	1.036	7.402	0.727	0.429	1.232	0.660	0.238	1.833
Other	1.521	0.366	6.310	1.464	0.635	3.374	0.504	0.137	1.849
US Citizen	0.504**	0.310	0.818	1.967**	1.293	2.991	1.002	0.552	1.818
Kids	0.884*	0.791	0.989	1.155**	1.052	1.268	0.978	0.865	1.106
Age	1.007	0.991	1.024	0.971***	0.957	0.986	1.024*	1.004	1.045
Income	0.888	0.748	1.053	0.866*	0.750	1.000	1.276**	1.087	1.498
City (Boston)									
Chicago	3.816***	2.597	5.605	0.336***	0.243	0.466	1.166	0.786	1.731
San Antonio	6.675***	4.348	10.248	0.082***	0.054	0.122	2.025**	1.248	3.286
Education (No Degree)									
HS Diploma/GED	0.740	0.531	1.032	0.735	0.525	1.030	2.311***	1.538	3.472
College Degree	0.460*	0.229	0.927	0.382***	0.216	0.675	5.306***	2.858	9.849
Work (Unemployed)									
Employed PT	1.082	0.715	1.636	0.975	0.678	1.403	1.012	0.620	1.651
Employed FT	0.572**	0.389	0.840	0.420***	0.302	0.586	3.691***	2.507	5.436
On Welfare	0.612**	0.424	0.882	3.060***	2.194	4.267	0.303***	0.177	0.520
Marital Status (Single)									
Cohabiting	1.087	0.661	1.788	0.795	0.503	1.256	1.270	0.668	2.415
Separated	0.793	0.533	1.181	1.154	0.739	1.803	1.167	0.687	1.984
Married	0.780	0.516	1.179	0.546**	0.374	0.797	2.383***	1.595	3.561
Health (Excellent/Very Good)									
Good	1.315	0.957	1.806	0.783	0.573	1.071	0.996	0.689	1.440
Fair/Poor	1.126	0.714	1.778	0.974	0.682	1.389	0.932	0.549	1.583
Health Problem	0.315***	0.167	0.596	4.560***	2.580	8.058	0.368*	0.146	0.924
Health Need	1.895**	1.244	2.886	0.572**	0.379	0.866	0.843	0.517	1.376
N	3276			3276			3276		
Log-Likelihood	-1638.962			-1574.318			-1431.442		
Chi^2	185.703			391.619			233.199		
Pseudo-R^2	0.167			0.301			0.240		

Note: Reference categories in parentheses; *Significant at p < .05; ** p < .01; *** p < .001

Work

As predicted, working full-time at T1 consistently and significantly affected women's health insurance status: compared to the unemployed, working full-time reduced low-income women's odds of being uninsured (0.572, $p < .01$) and having public health insurance (0.420, $p < .01$), while substantially increasing their odds of having access to private insurance at T2 (3.691, $p < .001$). Despite this finding, income produced less consistent effects, suggesting that the benefits of greater income do not necessarily translate into protection against being uninsured for low-income women. For example, as we might expect, each unit increase in income at T1 reduced women's odds of having public insurance (0.866, $p < .05$), while increasing women's odds of having private or employment based insurance (1.276, $p < .01$) at T2. But perhaps surprisingly, when examining low-income women's risk of being uninsured, increased income does not necessarily translate into reduced odds of being uninsured at T2 (as signified by no statistically significant effect for income in Model 1).

Welfare

As expected, compared to respondents who were not on welfare at T1, welfare recipients were significantly more likely to receive public health insurance (3.060, $p < .001$) and significantly less likely to be uninsured (0.612, $p < .01$) or have private insurance at T2 (0.303, $p < .001$).

Family

Marital status also had some significant lagged effects on low-income women's health insurance access. As hypothesized, compared to women who were single (and not cohabiting) at T1, being married reduced low-income women's odds of having public health insurance (0.546, $p < .01$) while significantly increasing their odds of having private or employer-provided health

insurance at T2 (2.383, $p < .001$). Despite these findings, there was little support for the hypothesis that marriage provides low-income women with long-term protection against being uninsured. Similarly, despite the opportunity for resource pooling, there was little evidence to support that cohabiting affects women's access to health insurance.

Health

Across all models, having a health problem that affected women's ability to work significantly affected their insurance access at later time points. Perhaps unsurprisingly, compared to those who did not experience health problems that affected their work, having a health problem at T1 reduced women's odds of having private or employment based insurance at T2 (0.368, $p < .05$). These women were also less likely to be uninsured (0.315, $p < .001$) and over four times more likely to have public health insurance at T2 (4.560, $p < .001$). In addition, those who experienced a health problem that they could not afford to address were significantly less likely to have access to public health insurance (0.572, $p < .01$) and more likely to be uninsured at T2 (1.895, $p < .01$). Together, these results suggest that public health insurance plays an important role in meeting the needs of low-income women with health problems and that those who are unable to qualify for such programs are at greater risk of having unmet medical needs due to cost.

Controls

In addition to the influence of welfare, work, family, and health factors in shaping low-income women's insurance status, several other factors also significantly affected women's access to various forms of health insurance at T2. For example, both Hispanic (2.770, $p < .05$) and non-citizen (1.984, $p < .01$) women faced significantly greater odds of being uninsured. Similarly, compared to non-citizens, citizens were more likely to have public health insurance at

T2 (1.967, $p < .01$). In addition, compared to those living in Boston, women living in Chicago and San Antonio faced significantly greater odds of being uninsured (3.816, $p < .001$; 6.675, $p < .001$) and lower likelihood of having public insurance (0.336, $p < .001$; 0.082, $p < .001$). Women in San Antonio also experienced greater odds of having private or employer-based health insurance (2.025, $p < .01$). These results suggest that despite the protective benefits of public programs for some women in some areas, other categories of women may face greater risk and vulnerability due to the rules and regulations of such programs and lack of access to private or employment based options.

Research Question 2

Are there significant differences between poor and near-poor women at Wave 1 in the lagged effects of welfare, work, and family status on their health insurance access over time?

Some of the findings described above, such as the effects of women's marital status on their access to public insurance, may be explained by separately exploring the effects of welfare, work, and family variables on different categories of women. Analyzing separate models for poor and near-poor women (as opposed to simply adding an interaction variable for poverty status in a combined model) allows me to determine if the variables in question operate differently for poor and near-poor women. In the following analyses (Models 4-9) I test for differences in the lagged effects of welfare, work, and family factors on low-income women's health insurance access at T2 by poverty status at T1. Although all low-income women experience significant vulnerabilities, because poor women may have greater access to public

programs and supports, we can expect to observe significant differences between poor and near-poor women in the importance of various welfare, work, and family factors in shaping their access to each form of insurance.

Specifically, I expect to find that near-poor women's access to full-time employment at T1 will make them more likely to have private or employer based insurance at T2, whereas poor women's access to full time employment will not provide the same benefit due to their particularly low wages and access to public insurance options (H2a). In addition, I expect to find poor women's access to welfare at T1 will increase their likelihood of being publicly insured and reduce their likelihood of being uninsured or privately insured at T2 and that these effects will be more pronounced for poor women than near-poor women (H2b). Finally, I expect to find that near-poor women's marital status at T1 plays a more significant role in affecting their access to both public and private insurance at T2 than poor women, namely, by reducing their likelihood of qualifying for public insurance due to resource pooling, while increasing opportunities for access to employer-based insurance options through marriage (H2c).

Table 4.2 displays the results of the logistic regression analyses for Models 4 and 5 examining poor and near-poor women's odds of being uninsured at T2. Table 4.3 displays the results for Models 6 and 7 examining poor and near-poor women's odds of having public insurance at T2. And Table 4.4 displays the results of Models 8 and 9 examining poor and near-poor women's odds of having private or employment based health insurance at T2. All independent variables are measured at T1. All tables provide the odds ratios and 95 percent confidence intervals for each model. The reference categories for dummy variables with more than two response categories are indicated in parentheses. Odds ratios and level of significance are also provided in parentheses in the text where appropriate.

When examining the odds of being uninsured at T2 (see Table 4.2), the model explains more of the variance for poor women than near-poor women. But in the public and private insurance models more variance in insurance status at T2 is explained for the category of near-poor women as indicated by the pseudo-R^2 values provided at the bottom of Tables 4.3 and 4.4. Specifically, in Model 4, nearly 17 percent of the variance in insurance status is explained by the model for near-poor women, whereas about 21 percent of the variance is explained in the same model for poor women (Model 5). In both the public and private insurance models the amount of variance explained is in the reverse direction; in Model 6 (see Table 4.3), 32 percent of the variance in public insurance access is explained by the model for near-poor women, while about 30 percent of the variance is explained in the model for poor women (Model 7). In the private or employer based health insurance models (see Table 4.4) there is an even larger disparity in the amount of variance explained; in Model 8, about 27 percent of the variance in health insurance status is explained in the model for near-poor women, while in Model 9, about 20 percent of the variance is explained in the model for poor women.

As described below, the results provide evidence of the differential effects of several variables on poor and near-poor women's risk of uninsurance and access to public and private forms of health insurance at T2. For example, although race and welfare access appear to play a more significant role in shaping poor women's odds of being uninsured, citizenship and employment appear to play a more significant role in shaping near-poor women's odds of being uninsured. The lagged effects of marriage and income are other factors that play differential roles in shaping poor and near-poor women's access to insurance. In addition, the effects of city characteristics suggest that city specific policy contexts make an important difference in shaping women's access to various public programs. Taken together the results provide evidence that

public programs play an important role in protecting poor women, while near-poor women must seek private insurance through employment in order to reduce the risk of negative outcomes across time.

Table 4.2 Logistic Regression Results Comparing Poor and Near-poor Women on Uninsured Status T2 (0=Has Insurance, 1=Uninsured)

	Near-poor T1 Model 4			Poor T1 Model 5		
T1 Predictors	Odds Ratio	95% Confidence Interval		Odds Ratio	95% Confidence Interval	
Time	0.221	0.009	5.376	3.037	0.275	33.530
Months	0.965	0.884	1.054	1.034	0.970	1.103
Race/Ethnicity (White)						
Black	2.969	0.688	12.810	1.349	0.486	3.748
Hispanic	3.483	0.783	15.496	2.864*	1.039	7.898
Other	1.316	0.178	9.711	1.658	0.326	8.425
US Citizen	0.458*	0.235	0.892	0.598	0.353	1.013
Kids	0.807*	0.655	0.994	0.898	0.785	1.027
Age	1.020	0.994	1.047	1.005	0.986	1.023
Income	0.790	0.585	1.068	1.086	0.736	1.604
City (Boston)						
Chicago	3.436***	1.882	6.273	4.497***	2.761	7.326
San Antonio	4.435***	2.324	8.465	9.638***	5.907	15.724
Education (No Degree)						
HS Diploma/GED	0.670	0.394	1.140	0.814	0.551	1.202
College Degree	0.607	0.247	1.488	0.375	0.119	1.178
Work (Unemployed)						
Employed PT	1.009	0.468	2.174	1.059	0.665	1.686
Employed FT	0.398**	0.219	0.726	0.675	0.395	1.152
On Welfare	0.858	0.424	1.734	0.541**	0.349	0.837
Marital Status (Single)						
Cohabiting	1.243	0.594	2.601	0.843	0.386	1.839
Separated	1.048	0.536	2.047	0.693	0.423	1.134
Married	0.723	0.392	1.335	1.012	0.620	1.653
Health (Excellent/Very Good)						
Good	2.028**	1.192	3.450	0.988	0.645	1.514
Fair/Poor	0.701	0.348	1.410	1.351	0.813	2.246
Health Problem	0.254	0.055	1.168	0.333***	0.195	0.567
Health Need	3.079***	1.576	6.014	1.550	0.883	2.723
N	1121			2155		
Log-likelihood	-537.269			-1044.297		
Chi^2	80.899			161.462		
Pseudo-R^2	0.173			0.209		

Note: Reference categories in parentheses; *Significant at $p < .05$; ** $p < .01$; *** $p < .001$

Table 4.3 Logistic Regression Results Comparing Poor and Near-poor Women on Public HI T2 (0=Not on Medicaid, 1=Has Medicaid)

	Near-poor T1 Model 6			Poor T1 Model 7		
T1 Predictors	Odds Ratio	95% Confidence Interval		Odds Ratio	95% Confidence Interval	
Time	0.463	0.029	7.311	0.442	0.043	4.600
Months	0.989	0.918	1.064	0.984	0.925	1.046
Race/Ethnicity (White)						
Black	0.841	0.339	2.090	0.893	0.468	1.706
Hispanic	0.655	0.275	1.556	0.713	0.373	1.364
Other	2.029	0.581	7.086	1.234	0.416	3.661
US Citizen	2.047*	1.050	3.990	2.015**	1.261	3.221
Kids	1.156	0.965	1.383	1.090	0.973	1.221
Age	0.950***	0.925	0.975	0.985	0.967	1.003
Income	0.908	0.722	1.142	1.308	0.888	1.927
City (Boston)						
Chicago	0.327***	0.186	0.574	0.287***	0.195	0.422
San Antonio	0.099***	0.048	0.203	0.064***	0.041	0.099
Education (No Degree)						
HS Diploma/GED	0.660	0.351	1.241	0.769	0.531	1.112
College Degree	0.699	0.237	2.059	0.238***	0.120	0.471
Work (Unemployed)						
Employed PT	1.495	0.691	3.234	0.775	0.508	1.182
Employed FT	0.451**	0.250	0.815	0.452***	0.293	0.699
On Welfare	2.625**	1.369	5.031	3.256***	2.173	4.878
Marital Status (Single)						
Cohabiting	0.918	0.449	1.875	0.645	0.380	1.096
Separated	1.039	0.490	2.201	1.199	0.723	1.987
Married	0.612	0.326	1.149	0.468***	0.301	0.728
Health (Excellent/Very Good)						
Good	0.554*	0.323	0.950	0.878	0.592	1.301
Fair/Poor	1.360	0.718	2.576	0.799	0.525	1.218
Health Problem	15.353***	4.535	51.973	2.464**	1.413	4.296
Health Need	0.581	0.275	1.228	0.550*	0.331	0.912
N	1121			2155		
Log-likelihood	-484.262			-1048.818		
Chi^2	181.424			291.569		
Pseudo-R^2	0.322			0.297		

Note: Reference categories in parentheses; *Significant at $p < .05$; ** $p < .01$; *** $p < .001$

Table 4.4 Logistic Regression Results Comparing Poor and Near-poor Women on Private/Employer HI T2 (0=No Priv/Emp HI, 1=Has Priv/Emp HI)

	Near-poor T1 Model 8			Poor T1 Model 9		
T1 Predictors	Odds Ratio	95% Confidence Interval		Odds Ratio	95% Confidence Interval	
Time	5.079	0.334	77.295	0.557	0.019	16.164
Months	1.031	0.957	1.112	0.973	0.891	1.062
Race/Ethnicity (White)						
Black	0.532	0.152	1.859	1.083	0.485	2.420
Hispanic	0.562	0.142	2.223	0.658	0.287	1.510
Other	0.469	0.087	2.546	0.421	0.075	2.376
US Citizen	1.147	0.548	2.399	0.865	0.465	1.611
Kids	1.066	0.875	1.298	1.014	0.876	1.175
Age	1.022	0.995	1.051	1.017	0.992	1.042
Income	1.276*	1.005	1.621	0.712	0.446	1.137
City (Boston)						
Chicago	1.118	0.614	2.035	1.285	0.764	2.160
San Antonio	1.991*	1.093	3.628	2.128**	1.240	3.652
Education (No Degree)						
HS Diploma/GED	2.198**	1.237	3.903	2.271**	1.362	3.787
College Degree	2.134	0.848	5.372	8.502***	4.157	17.386
Work (Unemployed)						
Employed PT	0.649	0.301	1.398	1.306	0.749	2.277
Employed FT	3.671***	2.101	6.414	3.584***	2.137	6.010
On Welfare	0.319*	0.116	0.878	0.278***	0.158	0.488
Marital Status (Single)						
Cohabiting	0.843	0.383	1.853	2.379	0.936	6.049
Separated	1.000	0.502	1.994	1.338	0.682	2.624
Married	2.026**	1.194	3.438	2.446**	1.396	4.287
Health (Excellent/Very Good)						
Good	0.885	0.539	1.453	1.179	0.710	1.959
Fair/Poor	1.138	0.557	2.328	0.872	0.451	1.686
Health Problem	0.026***	0.006	0.113	0.970	0.368	2.555
Health Need	0.417*	0.212	0.818	1.338	0.736	2.433
N	1121			2155		
Log-likelihood	-550.573			-803.904		
Chi^2	134.231			133.997		
Pseudo-R^2	0.269			0.202		

Note: Reference categories in parentheses; *Significant at $p < .05$; ** $p < .01$; *** $p < .001$

Work

Contrary to hypothesis H2a, nearly all models provide strong and consistent support for the effects of full-time employment on women's insurance access regardless of poverty status. Specifically, compared to the unemployed, both poor and near-poor women working full-time at T1 face significantly greater odds of having private or employment based insurance (see Table 4.4) and reduced odds of having public insurance at T2 (see Table 4.3). The only exception to this is found in Models 4 and 5 (see Table 4.2) which test the effects of the variables in question on poor and near-poor women's lack of access to insurance. Consistent with hypothesis H2a, full-time employment at T1 does not seem to provide the same protection against being uninsured for poor women as it does for near-poor women who, compared to unemployed women, are significantly less likely to be uninsured at T2 (0.398, $p < .01$). This may be due to poor women's use of differential strategies for guarding against being uninsured (i.e., the use of public health insurance), which is explored below.

In addition, the bifurcated effects of income on low-income women's lack of access to insurance (as described above and shown in Model 1) may be partially explained by women's poverty status at T1. For near-poor women, unit increases in income at T1 resulted in a significant increase in the odds of having private insurance at T2 (1.276, $p < .05$) while a similar effect was not observed for poor women (see Model 9). Post estimation hypothesis tests confirm a statistically significant difference between the income coefficients for poor (Model 9) and near-poor women (Model 8) in the private health insurance models ($F(1, 1712) = 5.10$, Prob > F = .024). These results suggest that the positive effects of increased income for women's insurance access may be limited to improving near-poor women's access to private insurance benefits, while there is little support that increased income results in improved outcomes for poor women.

Welfare

Contrary to hypothesis H2b, strong and consistent effects for welfare status were observed across both public and private health insurance models for both poor and near-poor women. Compared to women not on welfare, both poor and near-poor women on welfare at T1 were significantly more likely to have public health insurance (see Table 4.3) and significantly less likely to have private or employer based insurance at T2 (see Table 4.4). The only exception to this trend, and consistent with hypothesis H2b, was observed in the uninsured model (see Table 4.2), where compared to women not on welfare, poor women on welfare at T1 experienced significantly reduced odds of being uninsured at T2 (0.541, $p < .01$). A similar effect was not observed for near-poor women, suggesting that the benefits of welfare in protecting women against being uninsured are limited to poor women. Combined with the differential findings for full-time employment described above, these findings illustrate how poor and near-poor women use distinct strategies to protect themselves against being uninsured – for near-poor women full-time employment provides at least some level of protection against being uninsured, while poor women are able to utilize public programs and health insurance benefits to meet their health insurance needs. One potential consequence of this is that near-poor women may face greater risk and instability in their access to insurance than their poorer peers.

Family

As predicted, the effects of marriage were not always consistent for poor and near-poor women across all models. Nevertheless, contrary to hypothesis H2c, compared to single (not cohabiting) women, poor women married at T1 faced significantly reduced odds of being on public health insurance (see Table 4.3; 0.468, $p < .001$) although a similar effect was not observed for near-poor women. Also contrary to hypothesis H2c, marriage did not appear to have

a significant effect on either poor or near-poor women's lack of access to insurance (see Models 4 and 5), while compared to single women at T1, both near-poor (2.026, $p < .01$) and poor married women (2.446, $p < .01$) experienced increased odds of having private or employment based health insurance at T2 (see Table 4.4). Such results illustrate the nuanced mixed effects of marriage for low-income women; while marriage may act as a risk factor by reducing poor women's access to public forms of health insurance, the risk of marriage may be mitigated by improved access to private or employment based health insurance options as a dependent.

Health

Health measures produced extremely mixed results across models and groups of women providing evidence that near-poor women are particularly vulnerable to the negative effects of poor health and at greater risk of having unmet needs due to cost than their poorer peers, yet significantly more likely to gain access to public insurance options when they have health problems that affect their ability to work. For example, the only common finding across models for poor and near-poor women in the effects of health problems was observed in the public health insurance models (see Table 4.3) where compared to women who did not have a health problem that affected their ability to work at T1, both poor (2.464, $p < .001$) and near-poor (15.353, $p < .001$) women with health problems were significantly more likely to have public health insurance at T2. Nevertheless, post estimation hypothesis tests show that the difference in odds for poor and near-poor women was quite substantial with near-poor women being over 15 times more likely to be on public insurance at T2 when they have a health problem that affects their ability o work at T1 ($F(1, 1712) = 6.96$, Prob > F = 0.0084).

Although this finding would suggest that both poor and near-poor women benefit from public health insurance options, closer examination reveals that near-poor women may still

remain particularly vulnerable. For example, compared to women who did not have a health problem that affected their ability to work at T1, poor women with health problems were significantly less likely to be uninsured at T2 (0.333, $p < .001$) while a similar effect was not observed for near-poor women. In addition, compared to women who did not have a health need that went unmet due to cost, poor women with an unmet health need at T1 were significantly less likely to have public health insurance at T2 (0.550, $p < .05$). Both findings suggest that public health insurance programs play an important role in protecting poor women from being uninsured or failing to get access to care due to cost. The finding that compared to women in excellent/good health, near-poor women with good health were more likely to be uninsured (2.028, $p < .01$) and less likely to have public health insurance at T2 (0.554, $p < .05$) suggests that near-poor women with relatively good health may be more willing than their poorer peers to "risk" being uninsured due to the cost of private insurance and their inability to qualify for public programs.

Near-poor women, on the other hand, appeared to face more significant risks. For example, near-poor women with health problems affecting their ability to work at T1 were significantly less likely to have private or employment based insurance at T2 (0.026, $p < .001$). Compared to women who did not have a health need they were unable to meet due to cost at T1, near-poor women with unmet health needs were also significantly less likely to have private or employment based insurance at T2 (0.417, $p < .05$). In addition, compared to women who did not have an unmet health need, near-poor women with unmet health needs due to cost were also more likely to be uninsured at T2 (3.079, $p < .001$). Although these findings may be unsurprising, similar results were not observed for poor women. In fact, post estimation hypothesis tests also confirm statistically significant differences between the health need ($F(1,$

1712) = 6.73, Prob > F = 0.0096) and health problem (F(1, 1712) = 16.21, Prob > F = 0.0001) coefficients for poor (Model 9) and near-poor women (Model 8) in the private or employer based health insurance models (see Table 4.4). Such findings suggest that near-poor women may not benefit as readily from public programs as their poorer peers and thus face greater risk of being uninsured.

Controls

In addition to differences between poor and near-poor women in the influence of the welfare, work, family, and health factors described above, other important differences in the effects of several control variables were also observed. For example, the race and citizenship disparities identified in Model 1 and discussed above, appear to be specific to certain groups of women (see Models 4 and 5); whereas race seems to be more consequential for poor women, with Hispanic women being more likely to be uninsured at T2 (2.864, $p < .05$), citizenship appears to be more consequential for near-poor women, with non-citizen women significantly more likely to be uninsured at T2 (2.183, $p < .05$).

Several interesting findings were also observed for the city variables. For example, compared to those living in Boston, both poor and near-poor women living in Chicago and San Antonio faced significantly greater odds of being uninsured (see Table 4.2) with poor women in San Antonio facing the greatest increase in odds of being uninsured at T2 (9.638, $p < .001$). In fact, post estimation hypothesis tests confirm statistically significant differences between the San Antonio coefficients for poor (Model 5) and near-poor women (Model 4) in the uninsured models (F(1, 1712) = 4.12, Prob > F = 0.0425). Similarly, compared to those living in Boston, both poor and near-poor women in Chicago and San Antonio were significantly less likely to be on public health insurance at T2 (see Table 4.3). Nevertheless, and perhaps surprisingly,

compared to women in Boston, both poor and near-poor women in San Antonio were also significantly more likely to have private health insurance at T2 (see Table 4.4) although a similar finding was not observed for Chicago. Such findings suggest that state specific policies play a particularly important role in shaping women's access to health insurance programs either through the market or state.

Research Question 3

Given the lagged effects of welfare, work, and family statuses on low-income women's health insurance access, does health insurance access play a significant role in determining low-income women's economic status over time?

Models 10-11 test for the effects of welfare, work, family, and health and insurance factors on changes in low-income women's poverty status at T2. Because of the role of health insurance in affecting families' economic vulnerability, we can expect to observe that access to different forms of insurance will have differential effects on women's poverty over time. Specifically, I expect to find compared to those who are uninsured at T1, women with private forms of insurance will be less likely to move into poverty and more likely to move out of poverty at T2 (H3a). Although the benefits of public insurance access may not be observable because too much economic progress may result in loss of public insurance benefits, I hope to observe that women's access to public insurance at T1 reduces their odds of moving into poverty at T2 (i.e., by reducing their risk of medical debt, etc.) (H3b). Similarly, I also expect to find that access to private or employer-based insurance at T1 increases the odds of moving out of poverty at T2, although, once again, it is possible that because of variability in the extensiveness and cost

of private insurance, access to this form of insurance may not have consistent effects on women's economic progress over time (H3c).

Table 4.5 displays the results of the logistic regression analyses for Models 10-11 to determine if women's health insurance status at T1 affects changes in women's poverty status at T2. The dependent variable in these models measures women's change in poverty status from T1 to T2, where 0 represents no change, and 1 represents a change in poverty status. Model 10 is selected for women who were not poor at T1 and thus displays the factors that predict women's movement *into* poverty at T2. Model 11 is selected for women who were poor at T1 and thus displays the factors that predict women's movement *out* of poverty at T2. All independent variables are measured at T1. The table provides the odds ratios and 95 percent confidence intervals for each model. The reference categories for dummy variables with more than two response categories are indicated in parentheses. Odds ratios and level of significance are also provided in parentheses in the text where appropriate.

Although the work, family, welfare, health and control variables focused on in this study explained as much as almost 32 percent of the variance in public insurance access (see Model 6), they explain substantially less of the variance in poverty status, as indicated by the pseudo-R^2 values provided at the bottom of the table. Model 10 explains almost 13 percent of the total variance in women's movement into poverty at T2, and only 7 percent of the total variance in women's movement out of poverty at T2 (see Model 11). These findings alone suggest that the proposed models are insufficient for predicting changes in women's economic status over time.

Nevertheless, as described below, the results do show that resource pooling through cohabitation or marriage increases women's odds of moving out of poverty, while having fair or poor health significantly reduces women's odds of moving out of poverty. In addition, being on

public health insurance and welfare at T1 is associated with in an increase in women's odds of moving into poverty at T2, suggesting that near-poor women who qualify for public programs (despite strict income eligibility guidelines) must have other (unobserved) compelling circumstances that result in their movement into poverty over time.

Table 4.5 Logistic Regression Results Comparing Models With and Without Health Insurance Measures on Poverty Change T2 (0=No Change, 1=Change)

	Near-poor T1 Model 10 (Movement Into Poverty at T2)			Poor T1 Model 11 (Movement Out of Poverty at T2)		
T1 Predictors	Odds Ratio	95% Confidence Interval		Odds Ratio	95% Confidence Interval	
Time	0.187	0.018	1.965	1.255	0.161	9.769
Months	0.962	0.902	1.026	1.005	0.952	1.062
Race/Ethnicity (White)						
Black	0.891	0.394	2.013	0.754	0.390	1.455
Hispanic	0.936	0.395	2.219	0.704	0.360	1.376
Other	1.148	0.312	4.220	0.331	0.093	1.178
US Citizen	1.869*	1.019	3.429	1.009	0.608	1.673
Kids	1.093	0.914	1.308	0.979	0.874	1.096
Age	0.989	0.966	1.013	0.991	0.973	1.008
Income	0.796*	0.634	0.998	0.936	0.654	1.341
City (Boston)						
Chicago	1.247	0.753	2.064	0.672*	0.462	0.977
San Antonio	0.919	0.498	1.697	0.669	0.434	1.032
Education (No Degree)						
HS Diploma/GED	0.722	0.437	1.193	1.346	0.958	1.889
College Degree	0.767	0.334	1.763	1.807	0.917	3.559
Work (Unemployed)						
Employed PT	1.326	0.685	2.565	1.284	0.844	1.954
Employed FT	0.656	0.376	1.144	1.547	0.996	2.404
On Welfare	2.073*	1.157	3.714	0.769	0.534	1.108
Marital Status (Single)						
Cohabiting	0.669	0.351	1.273	2.459**	1.298	4.657
Separated	0.765	0.388	1.506	0.803	0.517	1.246
Married	0.599	0.337	1.063	1.774**	1.166	2.700
Health (Excellent/Very Good)						
Good	1.713*	1.057	2.776	0.745	0.516	1.076
Fair/Poor	1.086	0.564	2.092	0.676*	0.458	0.999
Health Problem	1.370	0.556	3.376	1.522	0.974	2.379
Health Need	0.822	0.417	1.619	1.621*	1.018	2.582
Insurance (Uninsured)						
Public HI	2.045*	1.152	3.631	0.742	0.492	1.119
Private/Employer HI	1.154	0.632	2.106	1.633	0.912	2.923
N	1117			2146		
Log-likelihood	-645.908			-1321.580		
Chi^2	86.659			74.538		
Pseudo-R^2	0.126			0.073		

Note: Reference categories in parentheses; *Significant at $p < .05$; ** $p < .01$; *** $p < .001$

Work, Welfare, and Family

As Table 4.5 shows, several welfare, work, and family variables play important roles in predicting changes in low-income women's poverty status over time. For example, as might be expected, Model 10 shows that unit increases in income at T1 reduce women's odds of moving into poverty at T2 (0.796, $p < .05$). Perhaps surprising though, the reverse effect is not observed in Model 11 predicting women's movement out of poverty. Model 10 also shows that being on welfare at T1 increases women's odds of moving into poverty at T2 (2.073, $p < .05$), which may indicate that near-poor women who qualify for welfare at T1 are experiencing significant (unobserved) life circumstances that make them likely to be in poverty over time. Model 11 provides evidence that compared to those who were single, married (1.774, $p < .01$) or cohabitating (2.459, $p < .01$) women (at T1) are more likely to move out of poverty at T2, suggesting an important lagged effect for resource pooling among couples. Model 11 also shows that compared to women who have excellent or very good health, women with fair or poor health at T1 are much less likely to move out of poverty at T2 (0.676, $p < .05$).

Contrary to my hypotheses, I find little evidence to support that women's health insurance status at T1 plays a significant role in shaping changes in women's poverty status over time. Specifically, in contrast to hypothesis H3b, Model 10 shows that compared to women who are uninsured, women on public insurance at T1 are significantly *more* likely to move into poverty at T2 (2.045, $p < .05$). Nevertheless, like the effect for welfare status (described above) this finding may simply indicate that near-poor women who qualify for public health insurance at T1 have significant unobserved factors that make them more likely to move into poverty over time. In this way, public health insurance access may serve as in indicator of poor economic health as opposed to a causal force affecting changes in women's economic status over time.

Several other surprising findings were observed. For example, Model 10 shows that both citizens (compared to non-citizens; 1.869, $p < .05$) and those with good health at T1 (compared to those with excellent or very good health; 1.713, $p < .05$) are more likely to move into poverty at T2. Although we might expect that having an unmet health need puts women at greater risk of moving into poverty over time, Model 11 shows that compared to those without a health need, women with a health need that goes unmet due to cost at T1 are actually more likely to move *out* of poverty at T2 (1.621, $p < .05$). Such perplexing results provide further support that these models are insufficient for predicting changes in low-income women's poverty status over time

Summary

In regards to my first research question I find that one's welfare, work, and family status at T1 does indeed have important lagged effects influencing one's insurance status at T2, that certain factors are more important in predicting changes in low-income women's health insurance status than others, and that the effects of these changes do vary by the type of insurance examined. The results of Models 1-3 show evidence that public programs like welfare and Medicaid provide important long-term protection against being uninsured or experiencing unmet health needs at later time points. Nevertheless, careful examination reveals that the benefits of public programs may be limited to certain segments of the low-income population such as non-Hispanic citizens.

But what about women who do not qualify for public programs? The results of my analysis show that protective factors related to employment, such as greater income, may produce bifurcated long-term results among low-income women – although greater income may provide some women with access to private or employer based health insurance options, others

are left more vulnerable at later time points due to their inability to qualify for public health insurance programs.

Marital status also had some significant lagged effects on low-income women's health insurance access. As hypothesized, compared to women who were single (and not cohabiting), being married reduced low-income women's odds of having public health insurance while significantly increasing their odds of having private or employer-provided health insurance at later time points. Despite these findings, there was little support for the hypothesis that marriage provides low-income women with long-term protection against being uninsured. Similarly, despite the opportunity for resource pooling, there was little evidence to support that cohabiting affects women's access to health insurance.

In addition to the effects of these welfare, work, and family factors, I find health related variables also play an important role in shaping women's access to various forms of insurance at later time points. These results suggest that public health insurance plays an important role in meeting the needs of low-income women with health problems and that those who are unable to qualify for such programs are at greater risk of having unmet medical needs due to cost.

In regards to my second research question, some of the initial findings - such as the bifurcated effects of increased income on women's health insurance status - may be partially explained by women's poverty status; for near-poor women, increased income results in a significant increase in the odds of having private insurance at later time points, but a similar effect is not observed for poor women. The lack of significant effects for income in the uninsured and public health insurance models may represent complex effects for increased income on women's access to public insurance options (while increasing income may reduce near-poor women's ability to qualify for public health insurance, the benefits of increased

income may not be realized immediately through a reduction in their risk of being uninsured). I attempted to capture the complex (perhaps curvilinear) effects of income using several transformations of income in several models (not shown), but these transformations similarly failed to capture these effects or improve the fit and explanatory power of the models so they were not included in the final analyses.

Nevertheless, the results do provide evidence of differential effects for several other variables on poor and near-poor women's risk of being uninsured and access to public and private forms of health insurance at later time points. For example, although race and marriage appear to play a more significant role in shaping poor women's odds of being uninsured and on public health insurance, income and health factors play a much more significant role in shaping near-poor women's access to insurance at later time points. In addition, full-time employment at T1 does not seem to provide the same protection against being uninsured for poor women as it does for near-poor women who, compared to near-poor unemployed women are significantly less likely to be uninsured at T2.

Finding that only poor women on welfare at T1 experienced significantly reduced odds of being uninsured at T2 suggests that the benefits of welfare in protecting women against being uninsured may be limited to poor women. Combined with the differential findings for full-time employment described above, these findings illustrate how poor and near-poor women use distinct strategies to protect themselves against being uninsured – for near-poor women full-time employment provides at least some women a level of protection against being uninsured, while their poorer peers are able to utilize public programs and health insurance benefits to meet their health insurance needs. One potential consequence of this is that near-poor women may face greater risk and instability in their access to insurance than poor women.

As predicted, the lagged effects of marriage are another factor that plays a differential role in shaping poor and near-poor women's access to insurance; while marriage may act as a risk factor for some poor women by reducing their access to public forms of health insurance, this risk may be mitigated by improved access for both poor and near-poor women to private or employment based health insurance options as a dependent.

Health measures also produced mixed results across models and groups of women providing evidence that near-poor women are particularly vulnerable to the negative effects of poor health and at greater risk of having unmet needs due to cost than their poorer peers. For example, poor women with health problems were significantly less likely to be uninsured at T2 while near-poor women with health problems were significantly less likely to have private insurance at T2. The solution for both groups of women may be public health insurance options, as both poor and near-poor women with health problems were more likely to have public health insurance. Despite this, near-poor women appeared to be particularly vulnerable to having unmet health needs due to cost as shown in the uninsured and private health insurance models. Such findings suggest that public health insurance programs play an important role in protecting low-income women from being uninsured or failing to get access to care due to cost.

Results also confirm that city differences play an important role in shaping the policy contexts which determine women's health insurance access. Compared to women living in Boston, women living in Chicago and San Antonio faced significantly greater odds of being uninsured and lower likelihood of having public insurance. Poor women in San Antonio appeared to face some of the greatest risks. State specific policies and income guidelines play a particularly important role for near-poor women in shaping their access to health insurance programs by either improving or hindering their access to public programs. These results suggest

that despite the protective benefits of public programs for some women in some areas, other categories of women may face greater risk and vulnerability due to the rules and regulations of such programs and lack of access to private or employment based options.

Despite the importance of women's health in shaping their economic prospects, in regards to my third research question, I find that including measures of health insurance access at T1 only offers a slight improvement in our ability to predict women's poverty status at T2. Although I hoped to observe a positive effect for women's access to both public and private health insurance on women's poverty status over time, it appears that being on Medicaid or having private health insurance may simply be an indicator of one's economic well-being instead of a causal force affecting one's economic status. Nevertheless, I do find that including health insurance measures provides evidence that public health insurance is an important program for women in poverty and women who do not qualify for such programs are at greater risk of having unmet health needs due to cost. This result provides further support for the findings described above, which illustrate the economic vulnerability of the near-poor who are unable to benefit from access to public programs like Medicaid. The implications and possible explanations of these findings are discussed further in Chapter 7.

CHAPTER FIVE

CHANGE ANALYSIS FINDINGS

In Chapter 4 I examined how factors at one time point affect women's access to insurance at later time points. In this Chapter I take a different approach to modeling the effects of various welfare, work and family factors on women's health insurance access over time by using measures of change to predict women's health insurance and poverty status. By comparing models using static measures with models using measures of change from T1 to T2, I can determine if experiencing change in any particular status impacts women's health insurance access and poverty differently than one's current marital, employment, or welfare status. One benefit of using measures of change is that they may provide a more nuanced understanding of the factors that affect women's access to insurance. For example, we know that one's marital status affects their options for health insurance, but does experiencing marital change, which may cause disruption in women's financial resources and program eligibility, similarly affect women's options? Are marital changes more or less consequential for low-income women's access to insurance? Using a series of logistic regression analyses we can determine how welfare, work, and family changes over time affect low-income women's insurance access, if the effects of these changes vary for different groups of low-income women, and whether health insurance changes affect low-income women's economic stability over time.

Research Question 1

What is the relative importance of individual-level welfare, work, and family changes in predicting low-income women's health insurance status over time?

Models 13, 15, and 17 test the effects of welfare, work, and family changes on low-income women's health insurance access. Models 12, 14, and 16 provide comparisons using static welfare, work, and family measures. Because there are different pathways to various forms of insurance, we might expect to observe differential effects for various changes by the type of health insurance being examined. Specifically, I expect to find that given the economic benefits of employment, employment changes that result in a reduction of work hours to fewer than 35 hours per week will have the biggest and most consistent effects on women's insurance access over time, resulting in increased likelihood of being uninsured or having public insurance and reduced likelihood of having private or employment based insurance (H1a). In addition, I expect to find that although Medicaid was officially delinked from welfare in 1996, changes that results in women's loss of welfare benefits will negatively impact their access to public health insurance. Given the economic vulnerability following loss of welfare benefits, I also expect to find that these women are more likely to be uninsured and less likely to have private or employment based insurance (H1b). Finally, given the legal and economic benefits of marriage, I expect to find that getting married or staying married have similar effects – reducing women's access to public insurance and odds of being uninsured, while increasing their odds of having private or employment based benefits (H1c).

Tables 5.1-5.3 display the results of the logistic regression analyses for Models 12-17. Models 12 and 13 use women's insurance status (insured or uninsured) at T2 as the dependent variable. Models 14 and 15 use women's public health insurance status at T2 as the dependent variable. And Models 16 and 17 use women's private or employment based health insurance status at T2 as the dependent variable. All independent variables included in these models are

measured at T2; the change variables measure changes in statuses from either Wave 1 to 2, or Wave 2 to 3. The results tables provide the odds ratios and 95 percent confidence intervals for each model. The reference categories for dummy variables with more than two response categories are indicated in parentheses. Odds ratios and level of significance are also provided in parentheses in the text where appropriate.

In Models 12 and 13, about 25 percent of the variance in insurance status is explained by the model, as indicated by the pseudo-R^2 value provided at the bottom of Table 5.1, with the change model offering little improvement in the amount of variance explained over the static model. In Models 14 and 15 the amount of variance explained increases dramatically, with the change model (Model 15) explaining slightly more of the variance in public health insurance status (40.2 percent) than the static model (38.4 percent). In Models 16 and 17, a similar improvement in the amount of variance explained is observed with the change model (Model 17) explaining 36.7 percent of the variance in private or employer based insurance and the static model explaining 34.2 percent. The improved fit and slight increase in the amount of variance explained by the change models suggests that including measures of one's welfare, work, and family changes helps us predict low-income women's insurance status at T2.

As described below, the results also provide evidence that examining measures of change provides a more nuanced understanding of how women's lives may affect their access to health insurance. In most models the effects of the change variables are consistent with their static counterparts. Nevertheless, variation in the odds between change categories shows that certain changes (or stability) may have more (or less) pronounced effects. For example, the benefits and risks associated with marriage in regards to women's access to public and private forms of health insurance appear to be restricted to those who are stably married as similar effects are not

observed for the newly married. In contrast, more mixed effects are observed for full-time employment change categories. For example, protection against being uninsured appears to be limited to those who are stably employed full-time, whereas women both newly employed full-time and stably employed full-time experience a reduction in access to public health insurance options. Finally, I also find mixed evidence that the delinking of welfare and public health insurance benefits has been successful in protecting women who are experiencing welfare changes from also losing their public health insurance benefits; even women with only temporary access to welfare appear to have improved odds of being on public insurance and reduced odds of being uninsured compared to those who have no access to welfare, yet their odds of having access to public insurance options are greatly reduced when compared to those with stable access to welfare.

Table 5.1 Logistic Regression Results Comparing Static and Change Variables for Uninsured T2 (0=Has Insurance, 1=Uninsured)

	Static Model 12			Change Model 13		
T2 Predictors	Odds Ratio	95% Conf Int		Odds Ratio	95% Conf Int	
Time	0.208	0.030	1.463	0.286	0.043	1.918
Months	1.043	0.989	1.099	1.035	0.983	1.089
Race/Ethnicity (White)						
Black	1.498	0.537	4.175	1.585	0.588	4.267
Hispanic	2.897*	1.005	8.354	2.904*	1.042	8.093
Other	1.536	0.378	6.254	1.735	0.443	6.797
US Citizen	0.413***	0.261	0.653	0.447***	0.279	0.717
Kids	0.935	0.836	1.046	0.945	0.843	1.059
Age	1.007	0.989	1.025	1.005	0.986	1.024
Income	0.796**	0.683	0.927	0.807**	0.693	0.941
City (Boston)						
Chicago	3.317***	2.233	4.925	3.578***	2.390	5.357
San Antonio	6.563***	4.327	9.953	6.648***	4.330	10.208
Education (No Degree)						
HS Degree/GED	0.797	0.563	1.129	0.763	0.533	1.090
College	0.511*	0.263	0.995	0.503*	0.263	0.963
Health (Excellent/Very Good)						
Good	1.120	0.785	1.598	1.039	0.720	1.499
Fair/Poor	0.809	0.500	1.308	0.803	0.496	1.301
Health Problem	0.259***	0.145	0.463	0.295***	0.168	0.519
Health Need	7.199***	4.794	10.810	6.669***	4.468	9.954
Employment (Unemployed)						
Employed PT	0.633*	0.419	0.957			
Employed FT	0.483***	0.320	0.730			
On Welfare	0.295***	0.177	0.492			
Marital Status (Single)						
Cohabiting	1.202	0.750	1.926			
Separated	0.609*	0.379	0.976			
Married	0.715	0.458	1.115			
Employment Change (Stayed Less than FT Employed)						
Lost FT Employment				0.575	0.264	1.254
Got FT Employment				0.731	0.433	1.235
Stayed Employed FT				0.386***	0.240	0.618
Welfare Change (Stayed Off Welfare)						
Moved Off Welfare				0.583*	0.372	0.913
Moved On Welfare				0.251***	0.124	0.509
Stayed On Welfare				0.273***	0.141	0.525
Marital Change (Stayed Single)						
Left Marriage				0.991	0.528	1.857
Got Married				0.735	0.405	1.334
Stayed Married				0.752	0.464	1.218
N	3269			3269		
Log-likelihood	-1475.303			-1470.960		
Chi^2	263.065			268.256		
Pseudo-R^2	0.248			0.250		

Note: Reference categories in parentheses; *Significant at p < .05; ** p < .01; *** p < .001

Table 5.2 Logistic Regression Results Comparing Static and Change Variables for Public HI T2 (0=Not on Medicaid, 1=Has Medicaid)

	Static Model 14			Change Model 15		
T2 Predictors	Odds Ratio	95% Conf Int		Odds Ratio	95% Conf Int	
Time	2.007	0.321	12.541	3.943	0.612	25.405
Months	0.990	0.943	1.039	0.974	0.928	1.024
Race/Ethnicity (White)						
Black	0.912	0.508	1.638	0.808	0.440	1.485
Hispanic	0.637	0.359	1.129	0.636	0.347	1.165
Other	1.354	0.484	3.790	1.373	0.481	3.918
US Citizen	2.067**	1.338	3.193	1.808**	1.178	2.776
Kids	1.264***	1.129	1.415	1.232***	1.103	1.376
Age	0.958***	0.944	0.973	0.966***	0.951	0.981
Income	0.776***	0.678	0.889	0.787***	0.688	0.901
City (Boston)						
Chicago	0.331***	0.227	0.484	0.300***	0.207	0.437
San Antonio	0.069***	0.045	0.106	0.069***	0.045	0.106
Education (No Degree)						
HS Degree/GED	0.719	0.508	1.017	0.783	0.550	1.114
College	0.443**	0.246	0.798	0.551*	0.311	0.979
Health (Excellent/Very Good)						
Good	0.896	0.633	1.269	0.933	0.653	1.332
Fair/Poor	1.166	0.794	1.714	1.218	0.833	1.781
Health Problem	5.721***	3.192	10.252	5.018***	2.835	8.881
Health Need	0.265***	0.163	0.432	0.251***	0.153	0.410
Employment (Unemployed)						
Employed PT	1.130	0.705	1.811			
Employed FT	0.342***	0.231	0.506			
On Welfare	5.418***	3.333	8.808			
Marital Status (Single)						
Cohabiting	0.952	0.619	1.464			
Separated	1.390	0.883	2.189			
Married	0.587**	0.402	0.856			
Employment Change (Stayed Less than FT Employed)						
Lost FT Employment				0.642	0.373	1.106
Got FT Employment				0.467***	0.303	0.720
Stayed Employed FT				0.228***	0.151	0.343
Welfare Change (Stayed Off Welfare)						
Moved Off Welfare				2.442***	1.628	3.664
Moved On Welfare				6.284***	3.095	12.758
Stayed On Welfare				7.946***	4.493	14.052
Marital Change (Stayed Single)						
Left Marriage				0.849	0.468	1.540
Got Married				1.075	0.656	1.762
Stayed Married				0.453**	0.281	0.732
N	3269			3269		
Log-likelihood	-1384.958			-1344.669		
Chi^2	405.882			481.908		
Pseudo-R^2	0.384			0.402		

Note: Reference categories in parentheses; *Significant at $p < .05$; ** $p < .01$; *** $p < .001$

Table 5.3 Logistic Regression Results Comparing Static and Change Variables for Private/Employer HI T2 (0=No Priv/Emp HI, 1=Has Priv/Emp HI)

	Static Model 16			Change Model 17		
T2 Predictors	Odds Ratio	95% Conf Int		Odds Ratio	95% Conf Int	
Time	1.791	0.201	15.966	0.662	0.069	6.363
Months	0.974	0.918	1.033	0.996	0.939	1.058
Race/Ethnicity (White)						
Black	0.723	0.223	2.345	0.804	0.279	2.321
Hispanic	0.593	0.154	2.290	0.588	0.180	1.925
Other	0.483	0.101	2.310	0.409	0.087	1.931
US Citizen	1.200	0.619	2.324	1.254	0.684	2.301
Kids	0.807**	0.705	0.924	0.840**	0.737	0.957
Age	1.039***	1.016	1.063	1.033**	1.009	1.057
Income	1.583***	1.353	1.853	1.567***	1.341	1.831
City (Boston)						
Chicago	1.317	0.843	2.057	1.335	0.853	2.089
San Antonio	2.396**	1.389	4.133	2.247**	1.303	3.873
Education (No Degree)						
HS Degree/GED	2.120**	1.343	3.347	2.128**	1.345	3.367
College	4.509***	2.258	9.004	3.950***	2.005	7.779
Health (Excellent/Very Good)						
Good	1.127	0.762	1.666	1.192	0.805	1.766
Fair/Poor	1.239	0.737	2.084	1.123	0.663	1.900
Health Problem	0.342**	0.173	0.676	0.361**	0.187	0.697
Health Need	0.197***	0.107	0.362	0.253***	0.139	0.459
Employment (Unemployed)						
Employed PT	2.137*	1.189	3.841			
Employed FT	7.059***	4.459	11.176			
On Welfare	0.315**	0.140	0.708			
Marital Status (Single)						
Cohabiting	0.864	0.512	1.458			
Separated	1.296	0.802	2.096			
Married	2.186**	1.360	3.515			
Employment Change (Stayed Less than FT Employed)						
Lost FT Employment				3.631***	1.860	7.088
Got FT Employment				3.429***	1.997	5.888
Stayed Employed FT				7.751***	5.036	11.931
Welfare Change (Stayed Off Welfare)						
Moved Off Welfare				0.518*	0.289	0.928
Moved On Welfare				0.572	0.254	1.290
Stayed On Welfare				0.054***	0.018	0.165
Marital Change (Stayed Single)						
Left Marriage				1.427	0.748	2.723
Got Married				1.444	0.711	2.932
Stayed Married				2.466***	1.508	4.033
N	3269			3269		
Log-likelihood	-1235.702			-1189.449		
Chi^2	296.763			281.335		
Pseudo-R^2	0.342			0.367		

Note: Reference categories in parentheses; *Significant at $p < .05$; ** $p < .01$; *** $p < .001$

Work

Consistent with hypothesis H1a, the static models show that compared to the unemployed, full-time employment significantly reduces low-income women's odds of being uninsured (Model 12; 0.483, $p < .001$) and having public health insurance (Model 14; 0.342, $p < .001$), while increasing their odds of having private or employment based insurance (Model 16; 7.059, $p < .001$). Perhaps surprisingly, Models 12 and 16 also show that compared to the unemployed, part-time employment also improves women's odds of having access to private or employer based insurance (2.137, $p < .05$) and reduces their odds of being uninsured (0.633, $p < .05$), although the effects of full-time employment are much stronger than the effects of part-time employment in both models.

The results produced in the change models are consistent with the static model findings, yet also provide important information about differences between categories of employment women based on whether the employment was sustained across time or is new. For example, in Model 13 we learn that the positive effects of full-time employment in reducing women's odds of being uninsured are limited to those women who are stably employed full-time (0.386, $p < .001$) as a similar significant effect is not observed for women who moved into full-time employment by T2. Nevertheless, Model 15 shows that the risks associated with loss of public health insurance options for the full-time employed are not limited to those who are stably employed full-time (0.228, $p < .0001$); even women who were newly employed full-time (i.e., had moved into full-time employment by T2) experienced reduced odds of being on public health insurance compared to those who did not have access to full-time employment across Waves 1 and 2 (0.467, $p < .001$).

Also consistent with its static counterpart, Model 17 shows that both new full-time employment (3.429, $p < .001$) and stable full-time employment (7.751, $p < .001$) are associated with increased odds of having private or employer based insurance at T2, although stable full-time employment results in more than double the odds of having access to private benefits than new full-time employment (see Table 5.3). Nevertheless, I was surprised to find that compared to women who stayed less than full-time employed, even women who lost full-time employment across Waves 1 or 2 also experienced an increase in odds of having private or employer based insurance at T2 (3.631, $p > .001$). Such findings suggest that there may be long-term benefits for women's access to full-time work in increasing their access to private insurance options, possibly through the use of programs such as COBRA, although this seems unlikely given the high cost of COBRA and the low-income of the sample women. It may be more likely that women leaving full-time employment may be doing so because of marriage, which improves their access to employment based health insurance as a dependent. Taken together, these results illustrate the complex effects of full-time employment for low-income women; while some women benefit from improved access to private forms of insurance, other women may suffer from reduced access to public health insurance options, putting them at greater risk of being uninsured.

Welfare

Although welfare was officially delinked from Medicaid in 1996, the static models provide strong evidence that having access to welfare is associated with improved health insurance access for low-income women. For example, although compared to women not on welfare, women on welfare are much less likely to have access to private or employment based insurance (Model 16; 0.315, $p < .01$); they are also significantly more likely to be on public

health insurance (Model 14; 5.418, $p < .001$) and much less likely to be uninsured (Model 12; 0.295, $p < .001$).

The change models provide more nuanced results that reveal some particularly interesting findings. Consistent with hypothesis H1b, the benefits associated with access to welfare for women's access to health insurance are extended to both those stably on welfare (0.273, $p < .001$) as well as those who are new to welfare (0.251, $p < .001$), resulting in reduced odds of being uninsured (see Model 13). Perhaps surprising, compared to women who were stably not on welfare, even women who recently moved off of welfare were less likely to be uninsured at T2 (0.583, $p < .05$), although the reduction in odds of being uninsured for this group of women was much less than for those with new or stable access to welfare (see Model 13). Similarly, even temporary welfare access was also associated with improved access to public health insurance benefits (see Model 15); compared to women who were not on welfare across Waves 1 or 2, both women who moved on to welfare (6.284, $p < .001$) and those who were stably on welfare (7.946, $p < .001$) were more likely to be on public health insurance. Nevertheless, as Table 5.1 shows, even women who moved off of welfare were also more likely to have public health insurance compared to women who stayed off welfare across Waves 1 or 2 (2.442, $p < .001$), although, once again, this group of women's odds of having access to public health insurance was much lower than women with new or stable access to welfare (see Model 15). These findings would appear to challenge hypothesis H1b by providing some evidence of a successful delinking of welfare and Medicaid benefits.

Nevertheless, a separate analysis (not shown) provides some evidence of much more risk for women leaving welfare. By altering the comparison group of the Welfare Change variable to women who were stably on welfare from Wave 1 to 2, or Wave 2 to 3, women who lost welfare

benefits from either wave faced significantly increased odds of being uninsured (2.253, $p < .05$) and reduced odds of having access to public health insurance benefits (0.323, $p < .001$). Together, the results show that when compared to women with no access to welfare, women who experience welfare changes have improved chances of getting access to public health insurance options which reduces their risk of being uninsured. But when compared to women who have stable access to welfare, women who experience welfare changes do not fare as well and are less likely to get access to public health insurance options which increases their odds of being uninsured.

Change Model 17 provides further support for the mixed effects of welfare access on women's access to private or employer based health insurance. As shown in Table 5.3, and perhaps unsurprising, compared to women who were stably off welfare from Wave 1 to 2, or Wave 2 to 3 women who stayed on welfare were significantly less likely to have private or employment based insurance (0.054, $p < .001$). More interesting is the finding that compared to women who were stably off welfare, women who moved off welfare across either wave were also significantly less likely to have private or employment based insurance (0.518, $p < .05$). Although this might suggest that women leaving welfare are at greater risk of being uninsured, the results of Model 15 suggest that some of these women may actually be able to maintain access to public health insurance, mitigating the risk of being uninsured (see Model 13).

Family

Contrary to hypothesis H1c, I find little evidence that either static or marital change measures affect low-income women's odds of being uninsured. Nevertheless, I do find consistent evidence across both static and change models to support the hypotheses regarding stable marriage and women's access to public and private forms of insurance. In static Models 14 and

16, compared to women who are single (and not cohabiting), married women are significantly less likely to have access to public health insurance (0.587, $p < .01$) and more likely to have access to private or employment based insurance (2.186, $p < .01$). Change Models 15 and 17 produce similar results; compared to women who stayed single across either Wave 1 or 2, women who stayed married were less likely to have public health insurance (0.453, $p < .01$) and more likely to have private or employer based insurance (2.466, $p < .001$). Nevertheless, contrary to hypothesis H1c, these results also suggest that the benefits and risks associated with marriage in regards to women's access to public and private forms of health insurance appear to be restricted to those who are stably married as similar effects were not observed for those who moved into marriage at T2.

Health

Consistent with the results of Chapter 4, women who experienced health problems that affected their ability to work were significantly less likely to have private insurance (see Table 5.3) but more likely to be on public health insurance (see Table 5.2) and less likely to be uninsured (see Table 5.1) than women who did not have health problems. Similarly, women who had health needs that went unmet due to cost were significantly more likely to be uninsured (see Table 5.1) and less likely to have either public health insurance (see Table 5.2) or private or employer based health insurance (see Table 5.3). These results are consistent across both the static and change models and provide evidence that public health insurance programs play an important role in both providing insurance to women with health problems and protecting low-income women from having unmet health needs. Low-income women without insurance, on the other hand, are at great risk of being unable to meet their healthcare needs.

Controls

Also consistent with the results of Chapter 4, in addition to the influence of welfare, work, family, and health factors in shaping low-income women's insurance status, several other factors also significantly affected women's access to various forms of health insurance at T2. For example, both Hispanic and non-citizen women faced significantly greater odds of being uninsured (see Table 5.1). Similarly, compared to non-citizens, citizens were more likely to have public health insurance at T2 (see Table 5.2). In addition, compared to those living in Boston, women living in Chicago and San Antonio faced significantly greater odds of being uninsured (see Table 5.1) and lower likelihood of having public insurance (see Table 5.2), while women in San Antonio also experienced greater odds of having private or employer-based health insurance (see Table 5.3). Finally, and also consistent with Chapter 4, both the static and change models show that while increased income reduces women's access to public health insurance options (see Table 5.2), it also increases their access to private or employer based health insurance (see Table 5.3) while reducing their risk of being uninsured (see Table 5.1). Taken together, these results suggest that despite the protective benefits of public programs for some women in some areas, other categories of women may face greater risk and vulnerability due to the rules and regulations of such programs and lack of access to private or employment based options.

Research Question 2

Are there significant differences between women who are poor and near-poor (at Wave 1) in the effects of welfare, work, and family changes on their health insurance access over time?

The results of the following analyses suggest that some of the effects of various welfare, work, and family changes on women's health insurance access may be specific to certain categories of low-income women. Analyzing separate models for poor and near-poor women (as opposed to simply adding an interaction variable for poverty status in a combined model) allows me to determine if the variables in question operate differently for poor and near-poor women. In the following analyses (Models 18-23) I test for differences in the effects of welfare, work, and family changes on low-income women's health insurance access at T2 by women's poverty status at T1. Although all low-income women experience significant vulnerabilities, because poor women may have greater access to public programs and supports, we can expect to observe significant differences between poor and near-poor women in the importance of various welfare, work, and family changes in shaping their access to each form of insurance.

Specifically, I expect to find that employment changes may have more profound effects for near-poor women than poor women due to poor women's ability to access public programs. Employment changes that result in access to full-time employment may also not provide poor women the same benefits in terms of access to private or employment based insurance as near-poor women due to their particularly low wages (H2a). In addition, I expect to find that even when they experience welfare changes, poor women will have greater likelihood of being publicly insured and reduced likelihood of being uninsured, whereas near-poor women who experience welfare changes may not benefit from these same protections. Nevertheless, near-poor women's loss of welfare status may result in greater likelihood of obtaining private or employer based insurance, whereas poor women may not obtain similar access to private or employer based benefits upon loss of welfare (H2b). Finally, I expect to find that family changes that result in the ending of a marriage or beginning of a marriage will have more significant

effects on near-poor women's access to both public and private insurance than poor women as poor women's access to public programs may protect them better from the negative effects of family changes (H2c).

Table 5.4 displays the results of the logistic regression analyses for Models 18 and 19 examining poor and near-poor women's odds of being uninsured at T2. Table 5.5 displays the results for Models 20 and 21 examining poor and near-poor women's odds of having public insurance at T2. And Table 5.6 displays the results of Models 22 and 23 examining poor and near-poor women's odds of having private or employment based health insurance at T2. All independent variables included in these models are measured at T2; the change variables measure changes in statuses from either Wave 1 to 2, or Wave 2 to 3. The analyses are separated by women's poverty status at T1. All tables provide the odds ratios and 95 percent confidence intervals for each model. The reference categories for dummy variables with more than two response categories are indicated in parentheses. Odds ratios and level of significance are also provided in parentheses in the text where appropriate.

When examining the odds of being uninsured at T2 (see Table 5.4), the model explains more of the variance for poor women (29 percent) than near-poor women (25 percent). The reverse is found for the private/employment based health insurance models (see Table 5.6); where 37.6 percent of the variance in private/employment based health insurance access is explained in the model for near-poor women, 33 percent of the variance is explained in the model for poor women. In the public health insurance model there is a negligible difference in the amount of variance explained, with models for both poor and near-poor women explaining about 40 percent of the variance (see Table 5.5).

As described below, the results provide evidence of the differential effects of several variables on poor and near-poor women's risk of being uninsured and access to public and private forms of health insurance at T2. For example, although citizenship plays a more significant role in shaping near-poor women's risk of being uninsured, welfare changes play a much more significant role in shaping poor women's risk of being uninsured. In regards to women's access to public insurance, I find that although full-time employment has similar effects on both poor and near-poor women's access to Medicaid, it has a much larger effect on near-poor women's ability to access public health insurance, while stable marriage appears to play a more significant role in shaping poor women's access to such programs. Poor women in San Antonio appeared to be particularly at risk of being uninsured and the least likely to have public health insurance benefits. Taken together, the results provide evidence that policy contexts and public programs play an important role in protecting low-income women, yet various welfare, work, and family changes play different roles in shaping poor and near-poor women's access to these benefits.

Table 5.4 Logistic Regression Results Comparing Poor and Near-poor Women on Uninsured T2 (0=Has Insurance, 1=Uninsured)

	Near-poor T1 Model 18			Poor T1 Model 19		
T2 Predictors	Odds Ratio	95% Confidence Interval		Odds Ratio	95% Confidence Interval	
Time	1.716	0.060	49.278	0.139	0.012	1.556
Months	0.992	0.907	1.086	1.052	0.986	1.124
Race/Ethnicity (White)						
Black	2.525	0.723	8.811	1.095	0.403	2.973
Hispanic	3.504	0.966	12.707	2.352	0.900	6.145
Other	1.084	0.198	5.943	1.410	0.312	6.383
US Citizen	0.356**	0.172	0.739	0.585	0.318	1.078
Kids	0.799*	0.651	0.981	0.984	0.861	1.125
Age	1.018	0.990	1.046	1.002	0.982	1.024
Income	0.812	0.657	1.003	0.821	0.668	1.008
City (Boston)						
Chicago	2.818**	1.484	5.352	4.549***	2.693	7.684
San Antonio	3.654***	1.919	6.957	10.280***	6.075	17.395
Education (No Degree)						
HS Degree/GED	0.729	0.404	1.317	0.858	0.557	1.320
College	0.490	0.175	1.374	0.684	0.329	1.424
Health (Excellent/Very Good)						
Good	1.386	0.788	2.436	0.823	0.517	1.309
Fair/Poor	0.544	0.261	1.135	0.893	0.522	1.529
Health Problem	0.220**	0.081	0.602	0.289**	0.137	0.609
Health Need	8.299***	4.286	16.069	6.003***	3.750	9.610
Employment Change (Stayed Less than FT Employed)						
Lost FT Employment	0.275**	0.114	0.663	0.824	0.324	2.093
Got FT Employment	1.328	0.506	3.484	0.587	0.318	1.083
Stayed Employed FT	0.377**	0.198	0.719	0.377*	0.178	0.797
Welfare Change (Stayed Off Welfare)						
Moved Off Welfare	0.714	0.303	1.687	0.580*	0.349	0.963
Moved On Welfare	0.345	0.072	1.657	0.178***	0.076	0.414
Stayed On Welfare	0.479	0.086	2.676	0.230***	0.116	0.457
Marital Change (Stayed Single)						
Left Marriage	0.430	0.136	1.361	1.485	0.722	3.053
Got Married	0.944	0.405	2.200	0.537	0.227	1.272
Stayed Married	0.725	0.364	1.443	1.004	0.559	1.805
N	1119			2150		
Log-likelihood	-486.011			-932.812		
Chi^2	103.487			230.352		
Pseudo-R^2	0.251			0.291		

Note: Reference categories in parentheses; *Significant at $p < .05$; ** $p < .01$; *** $p < .001$

Table 5.5 Logistic Regression Results Comparing Poor and Near-poor Women on Public HI T2 (0=No Medicaid, 1=Has Medicaid)

	Near-poor T1 Model 20			Poor T1 Model 21		
T2 Predictors	Odds Ratio	95% Confidence Interval		Odds Ratio	95% Confidence Interval	
Time	1.233	0.042	35.868	7.558	0.792	72.118
Months	1.004	0.919	1.097	0.959	0.903	1.018
Race/Ethnicity (White)						
Black	0.609	0.238	1.556	0.942	0.464	1.911
Hispanic	0.441	0.173	1.126	0.816	0.405	1.643
Other	1.545	0.293	8.147	1.353	0.412	4.445
US Citizen	1.458	0.737	2.882	2.077**	1.253	3.442
Kids	1.260*	1.040	1.525	1.205**	1.054	1.376
Age	0.952***	0.928	0.977	0.972**	0.953	0.991
Income	0.726**	0.592	0.890	0.848	0.710	1.013
City (Boston)						
Chicago	0.359**	0.186	0.691	0.243***	0.159	0.369
San Antonio	0.148***	0.071	0.309	0.042***	0.025	0.068
Education (No Degree)						
HS Degree/GED	0.868	0.469	1.608	0.722	0.483	1.079
College	0.601	0.198	1.827	0.506*	0.259	0.991
Health (Excellent/Very Good)						
Good	0.897	0.512	1.574	0.890	0.578	1.371
Fair/Poor	0.772	0.383	1.554	1.516	0.949	2.420
Health Problem	8.692***	2.843	26.574	3.722***	1.900	7.293
Health Need	0.235***	0.101	0.547	0.254***	0.139	0.463
Employment Change (Stayed Less than FT Employed)						
Lost FT Employment	0.611	0.246	1.520	0.654	0.330	1.296
Got FT Employment	0.261**	0.112	0.613	0.539*	0.316	0.920
Stayed Employed FT	0.208***	0.112	0.389	0.240***	0.138	0.419
Welfare Change (Stayed Off Welfare)						
Moved Off Welfare	2.089*	1.094	3.991	2.654***	1.609	4.378
Moved On Welfare	6.002***	2.275	15.834	7.419***	3.059	17.992
Stayed On Welfare	4.421**	1.510	12.939	10.248***	5.280	19.890
Marital Change (Stayed Single)						
Left Marriage	1.118	0.433	2.888	0.680	0.360	1.285
Got Married	1.044	0.478	2.281	1.180	0.616	2.260
Stayed Married	0.516	0.253	1.051	0.407**	0.221	0.751
N	1119			2150		
Log-likelihood	-430.398			-890.285		
Chi^2	193.397			322.053		
Pseudo-R^2	0.397			0.402		

Note: Reference categories in parentheses; *Significant at $p < .05$; ** $p < .01$; *** $p < .001$

Table 5.6 Logistic Regression Results Comparing Poor and Near-poor Women on Private/Employer HI T2 (0=No Priv/Emp HI, 1=Has Priv/Emp HI)

	Near-poor T1 Model 22			Poor T1 Model 23		
T2 Predictors	Odds Ratio	95% Confidence Interval		Odds Ratio	95% Confidence Interval	
Time	0.497	0.037	6.593	0.760	0.025	22.833
Months	1.004	0.935	1.077	0.993	0.907	1.086
Race/Ethnicity (White)						
Black	0.824	0.293	2.314	0.862	0.328	2.263
Hispanic	0.763	0.261	2.232	0.541	0.198	1.480
Other	0.543	0.084	3.506	0.360	0.049	2.661
US Citizen	1.604	0.783	3.288	1.052	0.453	2.442
Kids	0.983	0.807	1.197	0.799**	0.676	0.945
Age	1.030	0.997	1.065	1.032*	1.004	1.062
Income	1.519***	1.231	1.873	1.574***	1.266	1.957
City (Boston)						
Chicago	1.254	0.656	2.400	1.511	0.848	2.689
San Antonio	1.684	0.913	3.107	3.055***	1.602	5.828
Education (No Degree)						
HS Degree/GED	1.885*	1.001	3.551	2.178**	1.209	3.924
College	3.815*	1.217	11.961	3.408***	1.653	7.026
Health (Excellent/Very Good)						
Good	0.923	0.519	1.642	1.461	0.876	2.435
Fair/Poor	2.223*	1.147	4.308	0.746	0.377	1.479
Health Problem	0.277*	0.096	0.795	0.491	0.133	1.807
Health Need	0.259***	0.119	0.562	0.196***	0.082	0.469
Employment Change (Stayed Less than FT Employed)						
Lost FT Employment	4.981***	2.094	11.846	2.925*	1.094	7.823
Got FT Employment	3.459*	1.278	9.365	3.845***	1.993	7.416
Stayed Employed FT	8.069***	4.570	14.245	8.130***	4.389	15.060
Welfare Change (Stayed Off Welfare)						
Moved Off Welfare	0.544	0.203	1.458	0.448*	0.240	0.834
Moved On Welfare	0.296	0.086	1.018	0.666	0.256	1.734
Stayed On Welfare	0.044***	0.007	0.261	0.059***	0.015	0.227
Marital Change (Stayed Single)						
Left Marriage	2.602*	1.171	5.783	0.730	0.242	2.207
Got Married	1.152	0.495	2.680	1.765	0.644	4.836
Stayed Married	2.375*	1.217	4.635	2.125*	1.109	4.075
N	1119			2150		
Log-likelihood	-469.468			-673.051		
Chi^2	153.278			173.228		
Pseudo-R^2	0.376			0.330		

Note: Reference categories in parentheses; *Significant at $p < .05$; ** $p < .01$; *** $p < .001$

Work

Contrary to hypothesis H2b, I find that employment changes generally have similar effects on both poor and near-poor women's access to insurance at T2. For example, as Table 5.6 shows, compared to women who stayed less than full-time employed, both poor and near-poor women who are stably full-time employed or who experience any kind of change in full-time employment (even loss of full-time work) are significantly more likely to have private or employment based health insurance. Nevertheless, although there is relatively little variation between poor and near-poor women in the effects of employment changes on their access to private benefits, close examination reveals that some employment changes have larger effects than others. For example, as might be expected, women (both poor and near-poor) who maintain full-time employment across waves have the greatest odds of having private or employment based health insurance compared to those who experience an employment change.

The effects of employment changes on poor and near-poor women's access to public health insurance is also similar; compared to women who stayed less than full-time employed, both poor and near-poor women who are stably employed full-time or find new full-time employment are less likely to have public health insurance at T2. Despite similar effects for getting full-time work, consistent with hypothesis H2b, closer examination reveals that near-poor women see a much larger reduction in the odds of having public insurance than poor women. As table 5.5 shows, compared to women who stay less than full-time employed, poor women who move into full-time work by T2 are 46 percent less likely to have public health insurance (see Model 21; 0.539, $p < .05$) whereas near-poor women who move into full-time work by T2 are nearly 74 percent less likely to have public health insurance at T2 (see Model 20; 0.261, $p < .001$).

Mixed results were observed for the effects of employment changes on poor and near-poor women's risk of being uninsured at T2. As Table 5.4 shows, and consistent with hypothesis H2a, compared to women who stayed less than full-time employed across waves, poor and near-poor women who stayed full-time employed experienced an identical reduction in the odds of being uninsured (0.377, $p < .05$). Perhaps surprising though, and contrary to hypothesis H2a, compared to women who stayed less than full-time employed, near-poor women who lost full-time employment across waves were also significantly less likely to be uninsured at T2 (see Model 18; 0.275, $p < .01$). A similar effect was not observed for poor women. Taken together, these results suggest that the heightened risks near-poor women face in their reduced access to public health insurance following finding full-time work may be mitigated somewhat by improved access to private benefits following finding new full-time work.

Welfare

Consistent with hypothesis H2b, I find support that poor women who experience welfare changes are more likely to benefit from the protections of public insurance than near-poor women who may not meet strict eligibility guidelines. As Table 5.4 shows, the effects observed in Model 13 (see Table 5.1), which showed that welfare transitions did not increase women's risk of being uninsured, appear to be specific to poor women; compared to women who stayed off welfare across waves, poor women who stayed on welfare or experienced a change in their welfare status were all less likely to be uninsured at T2. Despite similar effects for all groups of poor women, close examination reveals important variation among welfare change categories. As might be expected, compared to women who stayed off of welfare across waves, poor women who stayed on welfare were 77 percent less likely to be uninsured (0.230, $p < .001$) whereas poor

women who moved off of welfare across waves were only 42 percent less likely to be uninsured at T2 (0.580, $p < .05$).

Table 5.5 shows that both poor and near-poor women who experienced welfare changes were more likely to have public health insurance than poor and near-poor women who stayed off of welfare across waves. Despite similarities in findings across categories of poor and near-poor women, close examination reveals notable differences in the size of the effects for poor and near-poor women. Consistent with hypotheses H2b, Model 21 shows that all categories of poor women were more likely to have public health insurance at T2 than near-poor women (see Model 20). For example, compared to poor women who stayed off of welfare across waves, poor women who stayed on welfare across waves were over ten times more likely to have public health insurance at T2 (see Model 21; 10.248, $p < .001$), whereas compared to near-poor women who stayed off of welfare across waves, near-poor women who lost welfare over time were only about twice as likely to have public health insurance at T2 (see Model 20; 2.089, $p < .05$).

Although these results might suggest that experiencing welfare changes is not detrimental to low-income women's access to public health insurance, it is important to take into consideration the comparison group in the models presented. In separate analyses (not shown) which alter the comparison group to be women who stayed on welfare across waves, women who moved off of welfare across waves did not fare as well; compared to women who stayed on welfare, both poor and near-poor women who moved off of welfare across waves were significantly less likely to have public health insurance at T2, with near-poor women experiencing the greatest reduction in access to public health insurance.

In terms of women's access to private or employer based health insurance, I also find some support for hypothesis H2b. Perhaps unsurprising, and as Table 5.6 shows, compared to

women who stayed off of welfare across waves, both poor (see Model 23; 0.059, $p < .001$) and near-poor women (see Model 22; 0.044, $p < .001$) who stayed on welfare across waves were significantly less likely to have private or employer based health insurance at T2. Nevertheless, Model 23 also shows that poor women who moved off of welfare across waves were also significantly less likely to have private or employer based health insurance at T2 than near-poor women who stayed off of welfare (0.448, $p < .05$). Taken together such findings show differential risks for both poor and near-poor women experiencing welfare transitions; poor women moving off of welfare may be less likely to have access to private or employer based insurance (see Model 23), but because they are more likely to have access to public health insurance despite their loss of welfare benefits (see Model 21) they may also be at less risk of being uninsured (see Model 19). Near-poor women who experience welfare changes, on the other hand, do not appear to benefit from the same protections against becoming uninsured (see Model 18).

Family

Perhaps surprising, Table 5.4 shows that compared to those who stayed single across waves, experiencing marital transitions did not appear to have a significant effect on poor or near-poor women's risk of being uninsured. Contrary to hypothesis H2c, Table 5.5 shows that the finding in Model 15 that stable marriage reduces women's access to public health insurance is specific to poor women; compared to women who stayed single across waves, poor women who stayed married across waves were significantly less likely to have public health insurance at T2 (see Model 21; 0.407, $p < .01$). Also contrary to hypothesis H2c, Table 5.6 shows that compared to women who stayed single across waves, both poor (see Model 23; 2.125, $p < .05$) and near-poor women (see Model 22; 2.375, $p < .05$) who stayed married were significantly

more likely to have private or employer based health insurance at T2. The only difference between the effects of poor and near-poor women's marital transitions on their access to private health insurance was observed for near-poor women who left a marriage across waves who perhaps surprisingly were significantly more likely to have private insurance compared to near-poor women who stayed single (see Model 22; 2.602, $p < .05$). Although we might assume that exiting a marriage would put near-poor women at greater risk of losing access to employer based health insurance as a dependent, it is possible that such a finding reflects the fact that near-poor women who have access to employment based benefits through their own work may feel more free to exit unsatisfactory marital relationships without risking their access to health insurance.

Health

Health related variables had similar effects for both poor and near-poor women's risk of being uninsured or having access to public insurance. Despite these similarities, the effects of health variables tended to be more pronounced for near-poor women than poor women. For example, while having a health problem that affects women's ability to work made poor women nearly four times more likely to have public health insurance than those who did not have similar health problems (see Model 21; 3.722, $p < .001$) having health problems made near-poor women nearly nine times more likely to have public health insurance than those who did not have similar health problems (see Model 20; 8.692, $p < .001$). Differences between poor and near-poor women in the effects of health related measures tended to be most pronounced in the private/employer-based health insurance models. As Table 5.6 shows, the finding in Model 17 that having a health problem reduced women's odds of having private or employer based insurance appears to be limited to near-poor women (see Model 22; 0.277, $p < .05$) as a similarly significant effect is not observed for poor women. In addition, Model 22 also shows that

compared to women with excellent or very good health, near-poor women with fair or poor health are significantly more likely to have private or employer based insurance at T2 (2.223, $p < .05$). Taken together, these findings suggest a much more complicated relationship between employment and health insurance access for near-poor women; although near-poor women who have health problems that affect their ability to work may be able to utilize public health insurance options to protect them against being uninsured, near-poor women who have poor health but are unable to qualify for public health insurance options may be compelled to maintain private/employment based benefits.

Controls

The effects of several control variables varied across models for poor and near-poor women. For example, in Model 15 we saw that citizenship and income factors were both important predictors of women's access to public health insurance at T2. But as Table 5.5 shows, the effects of these variables may be specific to certain categories of low-income women; whereas the effect of increased income in reducing women's access to public health insurance is significant for near-poor women (see Model 20; 0.726, $p < .01$), the effect of citizenship in increasing women's access to public health insurance is significant for poor women (see Model 21; 2.077, $p < .01$).

In addition to these differences, there were also consistent differences observed between poor and near-poor women in the effects of city controls on women's access to insurance. For example, although both poor and near-poor women living in Chicago and San Antonio were significantly more likely to be uninsured than those living in Boston, the difference in the effect of living in San Antonio on poor and near-poor women's risk of being uninsured was rather significant and confirmed by post estimation hypothesis tests ($F(1, 1707) = 6.37$, Prob > F =

0.012); poor women living in San Antonio were over ten times more likely to be uninsured at T2 that poor women living in Boston (see Model 19; 10.280, $p < .001$) whereas near-poor women living in San Antonio were closer to four times more likely to uninsured at T2 compared to near-poor women living in Boston (3.654, $p < .001$). A similar effect was observed for women's access to public health insurance (see Table 5.5); although both poor and near-poor women living in Chicago and San Antonio were less likely to have public health insurance at T2 than those living in Boston, poor women living in San Antonio were significantly less likely to have access to public health insurance than near-poor women living in San Antonio – a difference that was also confirmed by post estimation hypothesis tests ($F(1, 1707) = 8.02$, $Prob > F = 0.005$). Finally, although poor women living in San Antonio were significantly more likely to have private or employer-based insurance than poor women living in Boston (see Model 23; 3.055, $p < .001$) a similar effect was not observed for near-poor women living in Chicago. Such findings may reflect Texas's emphasis on market solutions to providing health care – an approach that leaves many poor women at greater risk of being uninsured, according to the findings of this analysis – and illustrates the importance of state-specific policy contexts for understanding low-income women's access to various forms of health insurance.

Research Question 3

Given the effects of welfare, work, and family changes on low-income women's health insurance access, do health insurance changes play a significant role in determining low-income women's economic status over time?

Models 24-29 test for the effects of welfare, work, family, and health insurance changes on changes in low-income women's poverty status at T2. Because of the role of health insurance in affecting families' economic vulnerability, we can expect to observe that different forms of insurance instability will have differential effects on women's poverty over time. Specifically, I expect to find that including measures of women's insurance changes will improve the amount of variance in women's poverty status explained, providing evidence that stable access to insurance plays an important role in women's economic progress. I also expect to find becoming uninsured or staying uninsured results in greater risk of moving into poverty and reduced odds of moving out of poverty at T2 (H3a). Although I would like to observe that women's stable access to public insurance reduces their odds of being in poverty at T2, it is likely that women's movement off of public insurance is an indication of women's economic progress and reduced risk of moving into poverty at T2 (H3b). Similarly, I also expect to find that transitioning into private or employment based insurance reduces women's odds of moving into poverty at T2, although, once again, it is possible that because of variability in the extensiveness and cost of private insurance, access to this form of insurance may not have consistent effects on women's economic progress over time (H3c).

Tables 5.7-5.9 display the results of the logistic regression analyses for Models 24-29 to determine if including measures of health insurance change helps us understand the factors that affect changes in women's poverty status. Models 24-25 include a general measure of changes in women's health insurance status (i.e., lost or got insurance across waves). Models 26-27 include a measure of women's public health insurance changes. And Models 28-29 include a measure of women's private or employment based health insurance changes. The dependent variable in these models measures whether a women experienced a change in poverty status over time or not

(0=no change in poverty status, 1=experienced a change in poverty status). Separate analyses are run for women who were not poor at T1 (Models 24, 26, and 28) and for those that were poor at T1 (Models 25, 27, and 29). Thus, for example, Model 24 tests the effects of welfare, work, family, and health factors on the odds of women's movement *into* poverty at T2, whereas Model 25 tests the effects of the same factors on women's movement *out* of poverty at T2. All independent variables included in these models are measured at T2; the change variables measure changes in statuses from either Wave 1 to 2, or Wave 2 to 3. The tables provide the odds ratios and 95 percent confidence intervals for each model. The reference categories for dummy variables with more than two response categories are indicated in parentheses. Odds ratios and level of significance are also provided in parentheses in the text where appropriate.

Although the work, family, and welfare change variables focused on in this chapter explain as much as 40 percent of the variance in women's access to public health insurance (see Model 15), they explain substantially less of the variance in low-income women's poverty status, as indicated by the pseudo-R^2 values provided at the bottom of Tables 5.7-5.9. The models testing factors related to women's movement into poverty over time (Models 24, 26, and 28) explain about 18 percent of the total variance in women's poverty status changes at T2. Whereas the models testing factors related to women's movement out of poverty over time (Models 25, 27, and 29) only explain about 10 percent of the total variance in women's poverty status changes at T2.

Although not shown, comparisons of models without measures of health insurance changes show that including measures of health insurance changes only offers a slight improvement in our ability to predict changes in women's poverty status at T2. Nevertheless, as described below, the models provide some evidence that changes in low-income women's access

to employment and private insurance, as well as changes in their access to welfare and public health insurance, do play a role in their movement into and out of poverty over time. As might be expected, getting or keeping full-time employment consistently affects the odds of women's movement into and out of poverty over time, as does women's access to stable marital relationships. Women's welfare, public health insurance, and private health insurances changes are less consistent predictors of women's poverty transitions over time – instead of causing women's poverty transitions it is highly possible that these transitions are simply reflections of women's poverty status transitions.

Table 5.7 Logistic Regression Results Comparing Models with Uninsured Measures on Poverty Change T2 (0=No Change, 1=Change)

	Near-poor T1 Model 24 (Move Into Poverty T2)			Poor T1 Model 25 (Move Out of Poverty T2)		
T2 Predictors	Odds Ratio	95% Confidence Interval		Odds Ratio	95% Confidence Interval	
Time	2.892	0.213	39.319	0.776	0.103	5.876
Months	0.972	0.905	1.044	1.005	0.953	1.060
Race/Ethnicity (White)						
Black	0.786	0.360	1.714	0.789	0.396	1.573
Hispanic	0.822	0.373	1.811	0.757	0.381	1.504
Other	1.256	0.364	4.336	0.392	0.114	1.351
US Citizen	1.227	0.656	2.298	0.825	0.494	1.379
Kids	1.173	0.987	1.394	0.862**	0.776	0.957
Age	0.992	0.971	1.014	0.996	0.979	1.013
City (Boston)						
Chicago	1.317	0.781	2.221	0.816	0.559	1.191
San Antonio	1.131	0.579	2.208	0.876	0.550	1.394
Education (No Degree)						
HS Degree/GED	0.794	0.498	1.268	1.546*	1.102	2.169
College	0.838	0.371	1.893	2.386**	1.418	4.013
Health (Excellent/Very Good)						
Good	1.040	0.603	1.793	0.942	0.642	1.383
Fair/Poor	1.279	0.745	2.193	0.883	0.583	1.336
Health Problem	0.771	0.404	1.474	1.167	0.711	1.918
Health Need	0.799	0.402	1.587	1.362	0.806	2.301
Employment Change (Stayed Less than FT Employed)						
Lost FT Employment	0.535	0.245	1.171	1.721	0.744	3.982
Got FT Employment	0.225**	0.080	0.629	2.438**	1.425	4.169
Stayed Employed FT	0.187***	0.108	0.323	2.749***	1.686	4.484
Welfare Change (Stayed Off Welfare)						
Moved Off Welfare	1.913	0.960	3.812	0.706	0.462	1.078
Moved On Welfare	2.624*	1.150	5.984	1.047	0.560	1.958
Stayed On Welfare	2.421*	1.079	5.434	0.600	0.360	1.001
Marital Change (Stayed Single)						
Left Marriage	0.685	0.325	1.443	1.493	0.648	3.442
Got Married	0.597	0.272	1.312	1.610	0.903	2.872
Stayed Married	0.358**	0.188	0.682	1.801*	1.089	2.977
Insurance Change (Stayed Insured)						
Got Insurance	0.554	0.298	1.028	1.478	0.922	2.369
Lost Insurance	1.102	0.539	2.252	0.902	0.512	1.587
Stayed Uninsured	0.719	0.309	1.674	0.683	0.389	1.198
N	1119			2148		
Log-likelihood	-610.426			-1298.908		
Chi^2	111.420			87.262		
Pseudo-R^2	0.176			0.091		

Note: Reference categories in parentheses; *Significant at $p < .05$; ** $p < .01$; *** $p < .001$

Table 5.8 Logistic Regression Results Comparing Models with Public HI Measures on Poverty Change T2 (0=No Change, 1=Change)

	Near-poor T1 Model 26 (Move Into Poverty T2)			Poor T1 Model 27 (Move Out of Poverty T2)		
T2 Predictors	Odds Ratio	95% Confidence Interval		Odds Ratio	95% Confidence Interval	
Time	3.103	0.236	40.841	0.940	0.117	7.532
Months	0.968	0.901	1.040	1.001	0.948	1.058
Race/Ethnicity (White)						
Black	0.816	0.393	1.697	0.747	0.373	1.499
Hispanic	0.881	0.420	1.851	0.691	0.347	1.378
Other	0.955	0.213	4.285	0.376	0.105	1.355
US Citizen	1.240	0.657	2.341	0.924	0.544	1.568
Kids	1.157	0.973	1.376	0.879*	0.790	0.977
Age	0.999	0.977	1.022	0.993	0.975	1.011
City (Boston)						
Chicago	1.402	0.829	2.370	0.676*	0.457	0.999
San Antonio	1.369	0.704	2.662	0.580*	0.362	0.929
Education (No Degree)						
HS Degree/GED	0.830	0.521	1.320	1.563*	1.099	2.222
College	0.959	0.404	2.272	2.292**	1.358	3.867
Health (Excellent/Very Good)						
Good	1.079	0.616	1.889	0.936	0.643	1.363
Fair/Poor	1.376	0.801	2.365	0.875	0.574	1.336
Health Problem	0.562	0.281	1.124	1.365	0.827	2.252
Health Need	0.868	0.437	1.726	1.091	0.644	1.850
Employment Change (Stayed Less than FT Employed)						
Lost FT Employment	0.570	0.269	1.208	1.697	0.751	3.836
Got FT Employment	0.261*	0.093	0.733	2.372**	1.352	4.160
Stayed Employed FT	0.243***	0.136	0.434	2.486***	1.522	4.061
Welfare Change (Stayed Off Welfare)						
Moved Off Welfare	1.801	0.923	3.513	0.848	0.544	1.322
Moved On Welfare	1.661	0.648	4.258	1.334	0.697	2.552
Stayed On Welfare	2.221	0.997	4.950	0.787	0.473	1.309
Marital Change (Stayed Single)						
Left Marriage	0.678	0.331	1.390	1.402	0.648	3.037
Got Married	0.629	0.287	1.378	1.665	0.918	3.020
Stayed Married	0.422*	0.215	0.829	1.603	0.953	2.697
Public Insurance Change (Stayed Off Medicaid)						
Lost Public HI	1.921	0.944	3.912	0.816	0.456	1.461
Got Public HI	3.440**	1.644	7.196	0.793	0.457	1.376
Stayed On Public HI	2.327**	1.256	4.310	0.480**	0.298	0.775
N	1119.000			2148.000		
Log-likelihood	-599.002			-1296.773		
Chi^2	113.458			101.295		
Pseudo-R^2	0.191			0.093		

Note: Reference categories in parentheses; *Significant at $p < .05$; ** $p < .01$; *** $p < .001$

Table 5.9 Logistic Regression Results Comparing Models with Private/Employer HI Measures on Poverty Change T2 (0=No Change, 1=Change)

	Near-poor T1 Model 28 (Move Into Poverty T2)			Poor T1 Model 29 (Move Out of Poverty T2)		
T2 Predictors	Odds Ratio	95% Confidence Interval		Odds Ratio	95% Confidence Interval	
Time	2.647	0.179	39.074	0.764	0.099	5.915
Months	0.972	0.903	1.046	1.008	0.955	1.063
Race/Ethnicity (White)						
Black	0.760	0.362	1.592	0.757	0.382	1.501
Hispanic	0.758	0.361	1.595	0.766	0.391	1.501
Other	1.010	0.275	3.716	0.444	0.134	1.469
US Citizen	1.315	0.722	2.394	0.869	0.521	1.449
Kids	1.196*	1.007	1.420	0.888*	0.800	0.986
Age	0.995	0.973	1.018	0.992	0.974	1.010
City (Boston)						
Chicago	1.198	0.728	1.974	0.781	0.540	1.130
San Antonio	1.043	0.562	1.935	0.717	0.466	1.104
Education (No Degree)						
HS Degree/GED	0.810	0.507	1.293	1.443*	1.019	2.044
College	0.976	0.388	2.455	2.040**	1.204	3.457
Health (Excellent/Very Good)						
Good	1.034	0.598	1.789	0.888	0.602	1.309
Fair/Poor	1.434	0.834	2.466	0.867	0.575	1.307
Health Problem	0.666	0.345	1.285	1.291	0.803	2.075
Health Need	0.701	0.382	1.285	1.427	0.856	2.376
Employment Change (Stayed Less than FT Employed)						
Lost FT Employment	0.638	0.299	1.364	1.546	0.686	3.482
Got FT Employment	0.262*	0.095	0.727	2.082*	1.184	3.660
Stayed Employed FT	0.257***	0.143	0.463	1.946*	1.147	3.301
Welfare Change (Stayed Off Welfare)						
Moved Off Welfare	2.098*	1.080	4.074	0.800	0.527	1.213
Moved On Welfare	2.193	0.937	5.133	1.225	0.642	2.337
Stayed On Welfare	2.638*	1.143	6.089	0.739	0.449	1.216
Marital Change (Stayed Single)						
Left Marriage	0.692	0.330	1.451	1.500	0.665	3.383
Got Married	0.600	0.268	1.342	1.549	0.862	2.781
Stayed Married	0.389**	0.199	0.760	1.551	0.919	2.620
Private/Employer HI Change (Stayed Off Private/Employer)						
Lost Priv/Employ HI	1.978	0.935	4.184	1.156	0.524	2.551
Got Priv/Employ HI	0.569	0.257	1.259	2.823***	1.569	5.078
Kept Priv/Employ HI	0.538	0.267	1.082	3.104**	1.443	6.677
N	1119.000			2148.000		
Log-likelihood	-598.709			-1279.504		
Chi^2	102.272			90.476		
Pseudo-R^2	0.192			0.105		

Note: Reference categories in parentheses; *Significant at $p < .05$; ** $p < .01$; *** $p < .001$

Work, Welfare, and Family

Consistent across all models, and as might be expected, I find that getting and keeping full-time work is both associated with a significant reduction in the odds of low-income women's movement into poverty and a significant increase in the odds of women's movement out of poverty over time. As Tables 5.7-5.9 show, although those who were stably married were consistently less likely to move into poverty over time than those who were single, experiencing marital transitions appeared to be a less consequential predictor of women's poverty changes.

Welfare transitions also had less consistent effects on women's poverty transitions across models, playing a significant role in shaping women's movement into poverty in several models but not predicting women's movement out of poverty over time. For example, in Model 24, which includes a general measure of women's insurance status, compared to those who stayed off of welfare over time, those who moved on to welfare (2.624, $p < .05$) and those who stayed on welfare (2.421, $p < .05$) were significantly more likely to move into poverty at T2. In Model 28, which includes a measure of women's private/employer insurance transitions, we find that women who moved off of welfare were also significantly more likely to move into poverty at T2 (2.098, $p < .05$). Although it may not be surprising that women who move into and stay on welfare are more likely to move into poverty over time, finding that women's movement off of welfare increases their risk of moving into poverty provides compelling evidence of the economic risks low-income women may encounter when leaving welfare. Furthermore, the lack of effects of welfare transitions on women's movement out of poverty over time suggest that exiting welfare may not necessarily indicate women's economic progress over time.

Health

Although I observed in parts one and two of this chapter that several health factors play an important role in shaping women's access to various forms of insurance, surprisingly, none of the women's health status measures were significant predictors of women's poverty transitions over time. Nevertheless, I did find some evidence that certain kids of health insurance transitions may be related to women's poverty changes over time. Contrary to hypothesis H3b, I find little evidence that loss of public insurance represents women's movement out of poverty. As Table 5.8 shows, I find that compared to those who lack access to Medicaid over time, getting on (3.440, $p < .01$) and staying on public health insurance (2.327, $p < .01$) are actually associated with increased odds of moving into poverty over time (see Model 26), while staying on public health insurance is also associated with a reduction in the odds of women's movement out of poverty over time (see Model 26.1; 0.480, $p < .01$).

Nevertheless, I do find evidence to support hypothesis H3c, that gaining private or employment based insurance increases women's odds of moving out of poverty over time. As Table 5.9 shows, I find that compared to those who lack access to private insurance over time, staying on private insurance (3.104, $p < .01$) or getting private insurance (2.823, $p < .001$) is associated with an increase in odds of moving out of poverty over time (see Model 29). Contrary to hypothesis H3a, I found no relationship between women's general insurance transitions and their poverty changes over time (see Table 5.7). Taken together these results suggest that women's private/employer health insurance transitions are better indicators of women's movement out of poverty over time, whereas women's public insurance transitions are better indicators of women's movement into poverty over time.

Finally, as Table 5.8 shows, when including measures of public health insurance transitions, I find that compared to women living in Boston, those living in Chicago (0.676, $p <$

.05) and San Antonio (0.580, $p < .05$) are significantly less likely to move out of poverty over time. Once again, such findings suggest that state-specific policy contexts play a significant role in shaping women's access to benefits, which in turn affect their economic opportunities and progress over time.

Summary

In regards to my first research question I find that low-income women's welfare, work, and family changes do indeed have important effects on women's insurance status at T2, that certain changes are more important in predicting low-income women's health insurance status than others, and that the effects of these changes do vary by the type of insurance examined. Full-time employment changes were important across models, yet had differential effects depending on the type of insurance examined. For example, the positive effects of full-time employment in reducing women's risk of being uninsured appeared to be limited to those who are stably employed full-time. Although full-time employment typically had larger effects on women's access to insurance, women both newly employed full-time and stably employed full-time experienced a similar reduction in access to public health insurance at T2, as well as increased odds of having private or employer-based insurance. Although it may be tempting to assume that low-income women who gain access to full-time work over time are able to meet their needs for health insurance in the private market, the fact that I do not observe a reduction in odds of being uninsured for women who are newly employed full-time suggests that at least some women may be at increased risk due to loss of public health insurance benefits. In this way a positive life change, like gaining full-time work, may initially have negative consequences for low-income women.

I find mixed evidence that the delinking of welfare and public health insurance benefits that occurred with welfare reform has been successful in protecting women who are experiencing welfare changes from also losing their public health insurance benefits. Models 13 and 15 show that even women with only temporary access to welfare appear to have improved odds of being on public insurance and reduced odds of being uninsured compared to those who have no access to welfare. Nevertheless, variation in odds between groups shows that women with stable access to welfare have the best outcomes in terms of access to public health insurance and reduced risk of being uninsured at T2. While these results provide some support for successful delinking, in separate analyses I find that compared to women who are stably on welfare across waves, women who lose welfare benefits are significantly more likely to be uninsured and less likely to have public health insurance benefits. In this case the comparison group really matters – while women who lose welfare over time may have better access to public health insurance options than women with no access to welfare, losing welfare benefits still puts women at greater risk of being uninsured than women with stable access to welfare as these women may not immediately be able to gain access to private or employer-based health insurance (see Model 17).

Surprisingly, marital changes did not appear to have significant effects on women's access to insurance. I find that the benefits and risks associated with marriage in regards to women's access to public and private forms of health insurance are restricted to those who are stably married as similar effects are not observed for the newly married. Statistically significant negative effects were also not observed for women exiting marital relationships. While stable marriage over time appears to increase low-income women's access to private or employment based insurance options, it also simultaneously reduces their odds of having access to public health insurance. The lack of finding that marriage reduces low-income women's risk of being

uninsured illustrates the contradictory effects of marriage on low-income women's access to insurance; while some women benefit from marriage, others suffer a marriage penalty when it comes to health insurance access.

In regards to my second research question, I find some support that certain changes affect poor and near-poor women differently, while other changes have similar effects on both groups of women. For example, compared to women who stayed less than full-time employed across waves, poor and near-poor women who stayed full-time employed experienced an identical reduction in the odds of being uninsured at T2 (see Table 5.4). Also contrary to what I expected to find, while there was significant variation between categories of employment change in predicating women's access to private benefits (i.e., stable full-time employment increases women's odds of having private benefits more than new full-time employment), there was little variation between poor and near-poor women in the effects of these changes. Although employment changes have similar effects on poor and near-poor women's access to public health insurance (i.e., both stable and new full-time employment reduces women's access to public health insurance) closer examination revealed that near-poor women experienced a much larger reduction in the odds of having public insurance than poor women (74 percent versus 46 percent, see Models 20 and 21).

More notable and consistent differences between poor and near-poor women were observed for the effects of welfare changes on women's access to insurance. Although both poor and near-poor women who experienced welfare changes were more likely to have public health insurance than women with no welfare access over time, poor women appeared to benefit most as evidenced by greater odds of having public insurance across all welfare change categories than near-poor women (see Table 5.5). Furthermore, the effects observed in Model 13, which

showed that welfare transitions did not increase women's risk of being uninsured, appear to be specific to poor women; compared to women with no welfare access across waves, poor women who stayed on welfare or experienced a change in their welfare status were all less likely to be uninsured at T2. Although this sounds hopeful for poor women, variations between categories of poor women suggest that welfare transitions do in fact put poor women losing welfare benefits at greater risk of being uninsured; compared to poor women who stayed off welfare across waves, poor women who stayed on welfare across waves were 77 percent less likely to be uninsured at T2, while poor women who moved off welfare were only 42 percent less likely to be uninsured at T2 (see Model 19). This may be due to the fact that poor women experiencing the loss of welfare across time were also significantly less likely to have private/employer health insurance at T2 (see Model 23).

Taken together such findings show differential risks for both poor and near-poor women experiencing welfare transitions; poor women moving off of welfare may be less likely to have access to private or employer based insurance (see Model 23), but because they are more likely to have access to public health insurance despite their loss of welfare benefits (see Model 21) they may also be at less risk of being uninsured (see Model 19). Near-poor women who experience welfare changes, on the other hand, do not appear to benefit as much from the same protections against becoming uninsured as poor women (see Model 18). Further evidence to support greater risk for women (especially near-poor women) moving off of welfare can be found by altering the comparison group in the analyses; although not shown, compared to women who stayed on welfare, both poor and near-poor women who moved off of welfare across waves were significantly less likely to have public health insurance at T2, with near-poor women experiencing the greatest reduction in access to public health insurance over time.

I also found some evidence that the risks and benefits of stable marriage may be different for poor and near-poor women. Although both poor and near-poor women who are stably married are more likely to have private health insurance than poor and near-poor women who remain single over time (see Table 5.6), the finding in Model 15 that stable marriage reduces low-income women's access to public health insurance appears to be specific to poor women as a similar marriage penalty was not observed for near-poor women (see Table 5.5). The only difference between the effects of poor and near-poor women's marital transitions on their access to insurance was observed for private health insurance, where near-poor women who left a marriage across waves were significantly more likely to have private insurance compared to near-poor women who stayed single (see Model 22). Although we might assume that exiting a marriage would put near-poor women at greater risk of losing access to employer based health insurance as a dependent, this finding may reflect the fact that near-poor women who have access to employment based benefits through their own work may feel more free to exit unsatisfactory marital relationships without risking their access to health insurance. Taken together, the results suggest that various welfare, work, and family changes play different roles in shaping poor and near-poor women's access to health insurance.

In regards to my third research question, I find that including measures of health insurance changes only offer a slight improvement in our ability to predict changes in women's poverty status at T2. Nevertheless, I do find some evidence that changes in low-income women's access to employment and private insurance, as well as changes in their access to welfare and public health insurance, do play a role in their movement into and out of poverty over time. For example, getting or keeping full-time employment consistently reduces the odds of moving into poverty while increasing the odds of moving out of poverty over time. Being stably married also

reduces low-income women's risk of moving into poverty over time. Women's welfare, public health insurance, and private health insurances changes were less consistent predictors of women's poverty transitions over time. Although it may be unsurprising that women who move into and stay on welfare are more likely to move into poverty over time (see Model 24), finding that women's movement off of welfare increases their risk of moving into poverty (see Model 28) provides compelling evidence of the economic risks low-income women may encounter when leaving welfare. Furthermore, the lack of effects of welfare transitions on women's movement out of poverty over time suggest that exiting welfare may not necessarily indicate women's economic progress over time.

Similarly, I find little evidence that loss of public health insurance represents women's movement out of poverty over time, as getting on and staying on public health insurance are associated with increased risk of moving into poverty over time and a reduction in the odds of moving out of poverty over time (see Models 26 and 27). I do find evidence that keeping or gaining private or employment based insurance are associated with an increase in the odds of women's movement out of poverty over time (see Model 29). Nevertheless, instead of *causing* women's poverty transitions it is highly possible that these transitions are simply *reflections of* women's poverty status transitions; women's private/employer health insurance transitions may be better indicators of women's movement out of poverty over time, whereas women's public insurance transitions may be better indicators of women's movement into poverty over time.

In addition to the effects of welfare, work, and family changes on women's access to insurance and poverty status, consistent with the results of Chapter 4, I also find evidence that public health insurance programs play an important role in both providing insurance to women with health problems and protecting low-income women from having unmet health needs.

Nevertheless, the fact that women in Chicago and San Antonio are more likely to be uninsured, less likely to have public health insurance, and less likely to move out of poverty over time illustrates how the protective benefits of public programs for some women may be limited due to state specific rules and regulations. Poor women in San Antonio appeared to be particularly at risk of being uninsured and the least likely to have public health insurance benefits. Nevertheless, Model 23, for example, also showed that poor women living in San Antonio were significantly more likely to have private or employer-based insurance than poor women living in Boston. Taken together, the results provide evidence that state specific policy contexts play a critical role in shaping low-income women's access to public programs and health insurance options. The implications and possible explanations of these findings are discussed further in Chapter 7.

CHAPTER SIX

TRAJECTORY ANALYSIS FINDINGS

In Chapter 5 I examined how measures of change in women's welfare, work, family, and insurance status across two time points affect women's access to various types of insurance and poverty status. In this chapter I take a different approach to examining the nature of low-income women's lives by using trajectory measures, which consider changes across all three data collection time points, to predict women's health insurance and poverty status. Some argue that trajectories are better able to represent the dynamic nature of people's lives. Instead of measuring one's status at a certain time point, trajectories give us important information about an individual's experience prior to their current status, which may help explain variation between respondents who share a similar status at any given time point.

How a person arrived at a certain place may play an important role in their ability to access certain opportunities. By comparing models using cross-sectional measures with models using trajectory measures I can determine if experiencing changes in any particular status impacts women's health insurance access and poverty differently than one's current marital, employment, or welfare status. One benefit of using trajectory measures is that they may provide a more nuanced understanding of the factors that affect women's access to insurance. For example, we know that one's marital status affects their options for health insurance, but does experiencing several marital changes similarly affect women's options? Are the financial and personal disruptions caused by marital changes more or less consequential for low-income women's access to insurance? Using a series of logistic regression analyses we can determine how welfare, work, and family trajectories affect low-income women's insurance access, if the

effects of these trajectories vary for different groups of low-income women, and whether health insurance trajectories affect low-income women's economic stability.

Research Question 1

What is the relative importance of individual-level welfare, work, and family trajectories in predicting low-income women's health insurance status over time?

Because there are different pathways to various forms of health insurance, we might expect to observe differential effects for various factors by the type of insurance instability being examined. In general, I expect to find that employment, marital, and welfare trajectories that reflect greater disruption and less continuity will have more significant effects on women's access to both private and public forms of insurance and also put women at greater risk of being uninsured. Specifically, I expect to find that employment trajectories that reflect stable and continuous access to full-time work will increase women's odds of having private or employment based insurance while reducing their odds of being uninsured or having public insurance (H1a). I also expect to find that women with trajectories displaying either stable access to welfare or new access to welfare are more likely to have access to public insurance and less likely to be uninsured or have private or employment based insurance (H1b). Finally, I expect to observe that trajectories that do not lead to formal marriage will have minimal effects on women's access to private or employment based insurance or uninsured status, while increasing women's odds of access to public insurance. In addition, despite the potential for resource pooling among cohabiting couples, across all models I suspect that cohabitation will not have the same level of effects on women's access to insurance as stable, formal marriage (H1c).

Tables 6.1-6.3 display the results of the logistic regression analyses for Models 30-35. Unlike Chapters 4 and 5, the data are not stacked in the following models since changes are being measured across all three time points. The result is a much smaller sample size as each respondent is only represented once. Models 30 and 31 use women's insurance status (insured or uninsured) at Wave 3 as the dependent variable. Models 32 and 33 use women's public health insurance status at Wave 3 as the dependent variable. And Models 34 and 35 use women's private or employment based health insurance status at Wave 3 as the dependent variable. Models 31, 33, and 35 test the effects of welfare, work, and family trajectories on low-income women's health insurance access. Models 30, 32, and 34 provide cross-sectional comparisons in order to determine if more dynamic measures of women's are more useful for our understanding of women's insurance access. All cross-sectional independent variables included in these models are measured at Wave 3; the trajectory variables measure changes in statuses across all three waves. The results tables provide the odds ratios and 95 percent confidence intervals for each model. The reference categories for dummy variables with more than two response categories are indicated in parentheses. Odds ratios and level of significance are also provided in parentheses in the text where appropriate.

As Tables 6.1-6.3 show, the trajectory models explain slightly more variance than their cross-sectional counterparts as indicated by the pseudo-R^2 values provided at the bottom of the tables. Although the difference in the amount of variance explained is very small (21.1 percent versus 22.5 percent) in the uninsured models (see Table 6.1), the difference is slightly more substantial in the public (see Table 6.2; 37.1 percent versus 40.8 percent) and private/employer health insurance models (see Table 6.3; 34.6 percent versus 36.4 percent).[7]

[7] Log-likelihood and BIC tests, which assess model fit (analyses not shown), provide mixed support for the trajectory models over the cross-sectional models, suggesting that measures of women's welfare, work, and family

As described below, the results also provide evidence that using trajectory measures provides a more nuanced understanding of how the dynamic nature of low-income women's lives may affect their access to health insurance. In most models the effects of the trajectory variables are consistent with their cross-sectional counterparts. Nevertheless, variation in the odds between trajectory categories shows that certain work, welfare, and family trajectories may have more (or less) pronounced effects. For example, the benefits and risks associated with marriage in regards to women's access to public and private forms of health insurance appear to be restricted to those who are stably married as similar effects are not observed for the newly married. In contrast, more mixed effects are observed for employment trajectories. For example, low-income women's access to private or employment based insurance appears to be improved by both new and continuous full-time work, whereas only women who are continuously employed full-time experience a reduction in access to public health insurance options. Finally, I also find some evidence that the delinking of welfare and public health insurance benefits has been somewhat successful in protecting women who are experiencing welfare changes from also losing their public health insurance benefits; even women who move on and off of welfare appear to have improved odds of being on public insurance and are less likely to be uninsured compared to those who have no access to welfare.

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trajectories are more helpful in explaining low-income women's access to public health insurance at Wave 3 than their access to private/employer health insurance or their risk of being uninsured.

Table 6.1 Logistic Regression Results Comparing Cross-sectional and Trajectory Variables for Uninsured Wave 3 (0=Has Insurance, 1=Uninsured)

	Cross-sectional Model 30			Trajectory Model 31		
Wave 3 Predictors	Odds Ratio	95% Conf Int		Odds Ratio	95% Conf Int	
Months 2				0.988	0.908	1.076
Months 3				1.048	0.973	1.128
Race/Ethnicity (White)						
Black	2.031	0.663	6.221	2.094	0.706	6.212
Hispanic	4.395*	1.424	13.568	4.047*	1.358	12.061
Other	1.463	0.212	10.118	1.323	0.190	9.208
US Citizen	0.586	0.316	1.085	0.639	0.334	1.224
Kids	0.977	0.849	1.125	0.989	0.856	1.143
Age	1.011	0.988	1.035	1.005	0.982	1.029
Income	0.836	0.693	1.010	0.825*	0.684	0.996
City (Boston)						
Chicago	1.735*	1.028	2.927	1.972*	1.157	3.360
San Antonio	3.056***	1.786	5.230	3.424***	1.946	6.025
Education (No Degree)						
HS Degree/GED	0.710	0.458	1.102	0.654	0.417	1.024
College	0.529	0.250	1.118	0.459*	0.214	0.984
Health (Excellent/Very Good)						
Good	1.007	0.616	1.648	0.992	0.605	1.625
Fair/Poor	0.800	0.468	1.368	0.795	0.463	1.364
Health Problem	0.182***	0.089	0.374	0.176***	0.084	0.368
Health Need	6.198***	3.705	10.366	7.120***	4.200	12.071
Employment (Unemployed)						
Employed PT	0.813	0.475	1.391			
Employed FT	0.466**	0.261	0.831			
On Welfare	0.236***	0.110	0.508			
Marital Status (Single)						
Cohabiting	1.403	0.707	2.785			
Separated	0.698	0.369	1.319			
Married	0.858	0.497	1.482			
Employment Trajectory (Continuous Unemployed)						
Became Unemployed				0.870	0.459	1.649
Kept or Got PT Work				0.744	0.398	1.390
Continuous FT Employed				0.492	0.219	1.106
Moved into FT Work				0.388*	0.188	0.799
Welfare Trajectory (Continuously Off Welfare)						
Moved Off Welfare				0.529*	0.309	0.904
Continuously On Welfare				0.302*	0.097	0.940
Moved On Welfare				0.139***	0.055	0.348
Marital Trajectory (Continuously Single)						
Became Single				1.135	0.599	2.151
Started/Stayed Cohabiting				1.502	0.754	2.990
Continuously Married				0.795	0.388	1.631
Moved into Marriage				0.933	0.480	1.812
Continuously Separated				0.966	0.341	2.734
Moved into Separation				0.680	0.323	1.432
N	1642			1642		
Log-likelihood	-780.651			-766.270		
Chi^2	122.923			150.629		
Pseudo-R^2	0.211			0.225		

Note: Reference categories in parentheses; *Significant at $p < .05$; ** $p < .01$; *** $p < .001$

Table 6.2 Logistic Regression Results Comparing Cross-sectional and Trajectory Variables for Public HI Wave 3 (0=No Medicaid, 1=Has Medicaid)

	Cross-sectional Model 32			Trajectory Model 33		
Wave 3 Predictors	Odds Ratio	95% Conf Int		Odds Ratio	95% Conf Int	
Months 2				0.986	0.906	1.072
Months 3				0.991	0.925	1.061
Race/Ethnicity (White)						
Black	0.829	0.399	1.722	0.760	0.342	1.691
Hispanic	0.521	0.247	1.101	0.546	0.239	1.249
Other	0.930	0.258	3.353	1.022	0.238	4.397
US Citizen	1.603	0.934	2.750	1.318	0.748	2.321
Kids	1.215*	1.044	1.414	1.156	0.998	1.339
Age	0.953***	0.932	0.975	0.965**	0.943	0.988
Income	0.771**	0.645	0.921	0.773**	0.645	0.927
City (Boston)						
Chicago	0.558*	0.345	0.903	0.472**	0.278	0.799
San Antonio	0.109***	0.060	0.197	0.106***	0.058	0.197
Education (No Degree)						
HS Degree/GED	0.848	0.538	1.338	0.942	0.591	1.502
College	0.639	0.298	1.368	0.784	0.358	1.717
Health (Excellent/Very Good)						
Good	1.064	0.644	1.757	1.143	0.679	1.923
Fair/Poor	1.049	0.638	1.726	1.019	0.611	1.701
Health Problem	8.525***	3.553	20.456	8.955***	3.505	22.882
Health Need	0.286***	0.159	0.515	0.255***	0.139	0.469
Employment (Unemployed)						
Employed PT	1.041	0.579	1.874			
Employed FT	0.364***	0.207	0.641			
On Welfare	4.849***	2.394	9.819			
Marital Status (Single)						
Cohabiting	0.796	0.444	1.428			
Separated	1.426	0.741	2.747			
Married	0.532*	0.307	0.920			
Employment Trajectory (Continuous Unemployed)						
Became Unemployed				1.291	0.664	2.513
Kept or Got PT Work				1.226	0.605	2.485
Continuous FT Employed				0.158***	0.061	0.409
Moved into FT Work				0.581	0.288	1.170
Welfare Trajectory (Continuously Off Welfare)						
Moved Off Welfare				2.715***	1.738	4.242
Continuously On Welfare				5.568***	2.078	14.918
Moved On Welfare				8.350***	3.230	21.588
Marital Trajectory (Continuously Single)						
Became Single				0.831	0.457	1.513
Started/Stayed Cohabiting				0.756	0.416	1.372
Continuously Married				0.382*	0.162	0.899
Moved into Marriage				0.892	0.454	1.753
Continuously Separated				0.650	0.218	1.936
Moved into Separation				1.569	0.750	3.279
N	1642			1642		
Log-likelihood	-708.260			-666.518		
Chi^2	201.627			246.444		
Pseudo-R^2	0.371			0.408		

Note: Reference categories in parentheses; *Significant at $p < .05$; ** $p < .01$; *** $p < .001$

Table 6.3 Logistic Regression Results Comparing Cross-sectional and Trajectory Variables for Private/Employer HI Wave 3 (0=No Priv/Emp HI, 1=Has Priv/Emp HI)

	Cross-sectional Model 34			Trajectory Model 35		
Wave 3 Predictors	Odds Ratio	95% Conf Int		Odds Ratio	95% Conf Int	
Months 2				0.968	0.889	1.055
Months 3				0.932	0.856	1.015
Race/Ethnicity (White)						
Black	0.669	0.276	1.617	0.596	0.218	1.629
Hispanic	0.520	0.205	1.315	0.441	0.154	1.262
Other	1.136	0.321	4.022	1.044	0.263	4.141
US Citizen	1.886	0.861	4.130	2.160	0.974	4.791
Kids	0.794*	0.666	0.947	0.833*	0.699	0.992
Age	1.042**	1.015	1.070	1.030	1.000	1.062
Income	1.406**	1.097	1.803	1.395**	1.095	1.776
City (Boston)						
Chicago	1.319	0.727	2.392	1.279	0.678	2.414
San Antonio	2.196**	1.236	3.903	2.075*	1.123	3.837
Education (No Degree)						
HS Degree/GED	3.139**	1.577	6.247	2.851**	1.430	5.684
College	4.868***	1.941	12.207	4.514**	1.797	11.338
Health (Excellent/Very Good)						
Good	0.771	0.440	1.351	0.796	0.453	1.401
Fair/Poor	1.160	0.615	2.190	1.267	0.665	2.411
Health Problem	0.386	0.095	1.569	0.402	0.104	1.558
Health Need	0.301**	0.145	0.624	0.341**	0.166	0.701
Employment (Unemployed)						
Employed PT	2.488*	1.130	5.480			
Employed FT	9.166***	4.514	18.613			
On Welfare	0.415*	0.174	0.989			
Marital Status (Single)						
Cohabiting	1.180	0.533	2.611			
Separated	1.271	0.650	2.487			
Married	2.361*	1.170	4.762			
Employment Trajectory (Continuous Unemployed)						
Became Unemployed				0.678	0.214	2.152
Kept/Got PT Work				2.027	0.719	5.715
Continuous FT Employed				11.193***	4.026	31.115
Moved into FT Work				6.106***	2.364	15.768
Welfare Trajectory (Continuously Off Welfare)						
Moved Off Welfare				0.607	0.313	1.178
Continuously On Welfare				0.044**	0.005	0.365
Moved On Welfare				0.492	0.204	1.190
Marital Trajectory (Continuously Single)						
Became Single				0.928	0.447	1.926
Started/Stayed Cohabiting				1.153	0.513	2.591
Continuously Married				2.758*	1.136	6.692
Moved into Marriage				1.670	0.798	3.494
Continuously Separated				1.609	0.566	4.570
Moved into Separation				1.371	0.661	2.842
N	1642			1642		
Log-likelihood	-600.738			-583.640		
Chi^2	152.863			186.918		
Pseudo-R^2	0.346			0.364		

Note: Reference categories in parentheses; *Significant at $p < .05$; ** $p < .01$; *** $p < .001$

Work

As Tables 6.1-6.3 show, the effects of employment factors on women's access to health insurance are fairly consistent across both the trajectory and cross-sectional models. Nevertheless, use of trajectory measures reveals some important nuances in the effects of women's employment histories on their access to various forms of insurance. For example, in cross-sectional Model 30 we see that being employed full-time reduces women's odds of being uninsured (0.466, $p < .01$). Yet, in trajectory Model 31, and contrary to hypothesis H1a, we find that the effects of full-time employment on reducing women's odds of being uninsured are limited to the newly employed full-time; compared to women who were continuously unemployed, only women who moved into full-time work by Wave 3 were significantly less to be uninsured (0.388, $p < .05$). Although contrary to hypothesis H1a, this finding may suggest that low-income women are being very selective in deciding which jobs to take, only opting for new full-time work if it will give them access to private or employer based benefits given the risk full-time employment imposes on women's access to public health insurance benefits (see below).

Consistent with hypothesis H1a, I find that the effects of full-time employment on reducing women's access to public health insurance (as shown in Table 6.2, cross-sectional Model 32; 0.364, $p < .001$) are actually limited to those who are stably employed full-time across all three waves (as shown in trajectory Model 33; 0.158, $p < .001$) as new or part-time employment trajectories did not similarly affect women's access to public health insurance. Also consistent with hypothesis H1a, stable full-time employment trajectories were also associated with increasing women's odds of having access to private or employer-based health insurance (see Table 6.3, Model 35; 11.193, $p < .001$). Perhaps surprising though, even new employment

trajectories were also associated with improved odds of having access to private insurance options (6.106, $p < .001$), although stable full-time employment trajectories nearly double women's chances of having private insurance over new full-time employment trajectories (see Table 6.3).

Welfare

The relationship between women's welfare access and health insurance access was also consistent across both cross-sectional and trajectory models. Nevertheless, once again, the trajectory models provide other important information regarding women's attachments to the welfare state. Although trajectory Model 35 (see Table 6.3) shows that the effects of women's welfare status on reducing their access to private or employment based health insurance are limited to those continuously on welfare (0.044, $p < .01$), the effects of welfare on women's odds of being uninsured and access to public health insurance are observed across all welfare trajectories. As predicted in hypothesis H1b, both continuous and new access to welfare increased women's odds of being on public insurance (see Table 6.2, Model 33) and also reduced their odds of being uninsured (see Table 6.1, Model 31). Nevertheless, contrary to hypothesis H1b, even women who experienced trajectories leading to loss of welfare benefits were less likely to be uninsured (see Model 31; 0.529, $p < .05$) and more likely to have public health insurance (see Model 33; 2.715, $p < .001$) than women who were continuously off welfare. Although there are considerable differences in odds for women who moved off of welfare compared to women who were stably on welfare or new to welfare (in the direction that we would predict), such results provide some limited evidence of successful delinking of welfare benefits from public health insurance benefits.

Family

As shown in Table 6.1, no significant effects were observed for either the cross-sectional or trajectory measures in predicting women's risk of being uninsured. As expressed in hypothesis H1c, this may be due to the complex effects of marriage and resource pooling on low-income women's access to insurance; although marriage may decrease women's odds of being uninsured by allowing them access to private benefits as dependents, it may also simultaneously increase women's odds of being uninsured by limiting their access to public health insurance benefits. Although not shown, separate analyses using transformations of income were analyzed in an attempt to capture this effect, but none were found to be adequate or to affect the results of the analysis significantly, thus, they were not included in the final models presented here.

Despite the lack of significant findings for relationship measures in the uninsured models, as predicted in hypothesis H1c, marital status did have a significant and consistent effect on women's access to public and private health insurance options across both cross-sectional and trajectory models. For example, as Table 6.2 shows, compared to those who are single, married women are significantly less likely to have public health insurance (see Model 32; 0.532, $p < .05$) and more likely to have private or employer-based insurance (see Model 34; 2.361, $p < 05$). Nevertheless, the trajectory models reveal that these effects are limited to women who are continuously married across all three time points (see Tables 6.2 and 6.3) as similar effects are not observed for the newly married. Also consistent with hypothesis H1c, no significant effects were observed for cohabiters, suggesting a lack of benefit to informal resource pooling for women's access to health insurance options.

Health

Whether or not trajectory or cross-sectional models were used, the effects for health variables remained consistent across all models. For example, compared to women without a

health need, women who had a health need they felt they could not afford to address were significantly less likely to have private or employer based insurance (see Table 6.3) or to have public insurance (see Table 6.2), and significantly more likely to be uninsured (see Table 6.1). Reverse, yet consistent, effects were observed for women with health problems. Compared to women who did not have a health problem, women who did have a health problem that affected their ability to work faced significantly reduced odds of being uninsured (see Table 6.1) and significantly greater odds of having public health insurance (see Table 6.2). Such findings suggest that low-income women with health problems benefit greatly from access to public health insurance programs and that these programs are successful in protecting women against having unmet health needs due to cost.

Controls

Very few differences in the effects of control variables across the cross-sectional and trajectory models were observed. Consistent findings support that Hispanic respondents and those living in Chicago and San Antonio were significantly more likely to be uninsured (see Table 6.1). Similarly, increased income and living in Chicago and San Antonio were also associated with reduced odds of having access to public health insurance (see Table 6.2). As might be expected, the number of children women had decreased their odds of having private or employer based benefits, while increased income was associated with improved odds of having private or employer based benefits (see Table 6.3). Finally, compared to women living in Boston, women living in San Antonio also experienced greater odds of having private or employer based insurance (see Table 6.3) despite the fact that women in San Antonio were also the most likely to be uninsured (see Table 6.1).

Research Question 2

Are there significant differences between women who are poor and near-poor at Wave 1 in the effects of welfare, work, and family trajectories on their health insurance access over time?

The results of the following analyses suggest that some of the effects of various welfare, work, and family trajectories on women's health insurance access may be specific to certain categories of low-income women. Analyzing separate models for poor and near-poor women (as opposed to simply adding an interaction variable for poverty status in a combined model) allows me to determine if the variables in question operate differently for poor and near-poor women. In the following analyses (Models 36-41) I test for differences in the effects of welfare, work, and family trajectories on low-income women's health insurance access at Wave 3 by poverty status at Wave 1.

Although all low-income women experience significant vulnerabilities, because poor women may have greater access to public programs and supports, we can expect to observe significant differences between poor and near-poor women in the importance of various welfare, work, and family trajectories in shaping their access to each form of insurance. Specifically, I expect to find that trajectories leading to or reflecting stable full-time employment will have less significant effects for poor than near-poor women given poor women's ability to qualify for public health insurance (H2a). I also expect to find that even when poor women experience less stable welfare trajectories (i.e., lose welfare benefits) they will experience less significant impacts on their health insurance access than near-poor women who, when loosing welfare benefits, may be at greater risk of losing public health insurance and being uninsured than poor

women (H2b). Finally, I expect to observe that trajectories representing stable marriage or movement into marriage will have more profound effects for near-poor women by increasing their access to private insurance while reducing their access to public insurance. I also expect to find that trajectories reflecting stable or new cohabitation may not provide the same level of benefits for near-poor women that stable marriage provides given women's ability to access private insurance benefits as dependents through marriage (H2c).

Table 6.4 displays the results of the logistic regression analyses for Models 36 and 37 examining poor and near-poor women's odds of being uninsured at Wave 3. Table 6.5 displays the results for Models 38 and 39 examining poor and near-poor women's odds of having public insurance at Wave 3. And Table 6.6 displays the results of Models 40 and 41 examining poor and near-poor women's odds of having private or employment based health insurance at Wave 3. Models 36, 38, and 40 display results for near-poor women, whereas Models 37, 39, and 41 display results for poor women. All independent variables included in these models are measured at Wave 3; the trajectory variables measure changes in statuses across all three waves of data collection. The results tables provide the odds ratios and 95 percent confidence intervals for each model. The reference categories for dummy variables with more than two response categories are indicated in parentheses. Odds ratios and level of significance are also provided in parentheses in the text where appropriate.

As Tables 6.4-6.6 show, all models for near-poor women explain more of the variance in insurance status than the models for poor women. This may be partially the result of fewer observations in the near-poor models as more women were considered poor at Wave 1 than not poor. In near-poor Model 36 over 29 percent of the variance in women's risk of being uninsured is explained by the model, whereas in poor Model 37, 24 percent of the variance is explained.

Like in previous chapters, much more of the variance in women's access to public and private health insurance is explained by the models. For example, in near-poor Model 38 over 55 percent of the variance in women's access to public health insurance is explained, while only 37 percent of the variance is explained in the poor Model 39. Similarly, in near-poor Model 40, 43 percent of the variance in private/employer health insurance is explained by the model, whereas in poor Model 41 nearly 33 percent of the variance is explained. In the following section I focus my discussion on differences between groups of women in the effects of the trajectory variables only noting other significant variables where doing so may help explain the effects of the trajectory variables.

As described below, Tables 6.4-6.6 show some differences in the effects of various welfare, work, and family trajectories on poor and near-poor women's access to insurance, suggesting that some of the effects observed in the first part of this analysis can partially be explained by women's poverty status. For example, the observation that there are few differences between the various effects of welfare trajectories on women's access to public insurance and risk of being uninsured appear to be limited primarily to poor women. In addition, although employment trajectories had fairly consistent results for both poor and near-poor women, differences in the size of the effects varied somewhat with near-poor women experiencing greater effects on their access to public and private benefits than poor women. Such differences highlight the unique opportunities and risks poor and near-poor women face in securing health insurance benefits.

Table 6.4 Logistic Regression Results Comparing Poor and Near-poor Women on Uninsured Wave 3 (0=Has Insurance, 1=Uninsured)

	Near-poor W1 Model 36			Poor W1 Model 37		
Wave 3 Predictors	Odds Ratio	95% Conf Int		Odds Ratio	95% Conf Int	
Months 2	0.985	0.824	1.176	0.992	0.899	1.096
Months 3	1.120	0.974	1.288	1.014	0.933	1.102
Race/Ethnicity (White)						
Black	1.326	0.196	8.983	2.414	0.662	8.796
Hispanic	3.729	0.573	24.273	4.429*	1.180	16.629
Other	3.327	0.141	78.454	0.573	0.036	9.206
US Citizen	0.270*	0.089	0.817	0.839	0.380	1.854
Kids	0.642*	0.418	0.987	1.036	0.896	1.198
Age	1.017	0.966	1.070	1.007	0.981	1.033
Income	0.957	0.660	1.387	0.779*	0.621	0.976
City (Boston)						
Chicago	2.338	0.771	7.090	2.208*	1.174	4.151
San Antonio	4.188**	1.611	10.887	3.898***	1.964	7.737
Education (No Degree)						
HS Degree/GED	0.476	0.192	1.180	0.672	0.396	1.139
College	0.360	0.072	1.788	0.497	0.212	1.165
Health (Excellent/Very Good)						
Good	0.755	0.292	1.953	1.089	0.617	1.923
Fair/Poor	0.526	0.196	1.412	0.848	0.445	1.616
Health Problem	0.135**	0.036	0.507	0.163***	0.069	0.385
Health Need	9.377***	3.533	24.888	6.314***	3.493	11.411
Employment Trajectory (Continuous Unemployed)						
Became Unemployed	3.135	0.824	11.928	0.616	0.289	1.315
Kept or Got PT Work	0.884	0.193	4.053	0.719	0.353	1.464
Continuous FT Employed	0.643	0.168	2.452	0.380	0.117	1.235
Moved into FT Work	0.208*	0.055	0.791	0.534	0.236	1.209
Welfare Trajectory (Continuously Off Welfare)						
Moved Off Welfare	0.886	0.278	2.831	0.436**	0.246	0.775
Continuously On Welfare				0.316*	0.101	0.985
Moved On Welfare	0.247*	0.063	0.973	0.106***	0.032	0.354
Marital Trajectory (Continuously Single)						
Became Single	1.434	0.512	4.018	0.965	0.446	2.089
Started/Stayed Cohabiting	3.358	0.701	16.097	1.526	0.708	3.287
Continuously Married	0.695	0.194	2.496	0.892	0.367	2.168
Moved into Marriage	0.754	0.187	3.036	1.171	0.520	2.636
Continuously Separated	0.550	0.106	2.865	1.077	0.341	3.397
Moved into Separation	0.839	0.196	3.590	0.679	0.286	1.612
N	427			1205		
Log-likelihood	-177.240			-557.828		
Chi^2	66.951			112.946		
Pseudo-R^2	0.293			0.240		

Note: Reference categories in parentheses; *Significant at $p < .05$; ** $p < .01$; *** $p < .001$

Table 6.5 Logistic Regression Results Comparing Poor and Near-poor Women on Public HI Wave 3 (0=No Medicaid, 1=Has Medicaid)

	Near-poor W1 Model 38			Poor W1 Model 39		
Wave 3 Predictors	Odds Ratio	95% Conf Int		Odds Ratio	95% Conf Int	
Months 2	1.017	0.834	1.240	0.968	0.881	1.064
Months 3	0.854*	0.752	0.969	1.016	0.938	1.100
Race/Ethnicity (White)						
Black	0.309	0.059	1.620	1.274	0.461	3.522
Hispanic	0.166*	0.032	0.858	0.954	0.330	2.760
Other	0.070	0.004	1.258	4.899	0.690	34.801
US Citizen	1.205	0.336	4.323	1.463	0.749	2.857
Kids	1.233	0.820	1.854	1.114	0.959	1.294
Age	0.913**	0.858	0.971	0.975	0.950	1.000
Income	0.589*	0.385	0.900	0.806*	0.649	1.000
City (Boston)						
Chicago	0.486	0.160	1.479	0.436*	0.232	0.821
San Antonio	0.049***	0.014	0.172	0.105***	0.051	0.213
Education (No Degree)						
HS Degree/GED	0.575	0.183	1.804	1.072	0.636	1.808
College	1.220	0.255	5.838	0.836	0.329	2.124
Health (Excellent/Very Good)						
Good	1.531	0.586	4.002	1.045	0.570	1.916
Fair/Poor	0.747	0.253	2.205	1.068	0.596	1.913
Health Problem	38.029***	8.279	174.688	7.862***	2.767	22.340
Health Need	0.066***	0.018	0.239	0.316***	0.162	0.616
Employment Trajectory (Continuous Unemployed)						
Became Unemployed	0.421	0.072	2.455	1.771	0.840	3.736
Kept or Got PT Work	0.910	0.205	4.034	1.351	0.627	2.911
Continuous FT Employed	0.075**	0.011	0.499	0.204**	0.069	0.604
Moved into FT Work	0.316	0.082	1.222	0.707	0.306	1.637
Welfare Trajectory (Continuously Off Welfare)						
Moved Off Welfare	2.569	0.952	6.935	2.736***	1.627	4.600
Continuously On Welfare				5.327**	1.878	15.110
Moved On Welfare	5.282**	1.642	16.988	11.844***	3.370	41.626
Marital Trajectory (Continuously Single)						
Became Single	1.668	0.482	5.767	0.815	0.398	1.667
Started/Stayed Cohabiting	0.147**	0.039	0.560	1.044	0.533	2.045
Continuously Married	0.380	0.062	2.315	0.451	0.165	1.232
Moved into Marriage	0.879	0.220	3.515	0.940	0.445	1.988
Continuously Separated	0.148	0.003	7.066	0.761	0.239	2.420
Moved into Separation	1.848	0.525	6.508	1.507	0.637	3.565
N	427			1205		
Log-likelihood	-117.339			-523.007		
Chi^2	123.846			194.545		
Pseudo-R^2	0.554			0.374		

Note: Reference categories in parentheses; *Significant at $p < .05$; ** $p < .01$; *** $p < .001$

Table 6.6 Logistic Regression Results Comparing Poor and Near-poor Women on Private/Employer HI Wave 3 (0=No Priv/Emp HI, 1=Has Priv/Emp HI)

	Near-poor W1 Model 40			Poor W1 Model 41		
Wave 3 Predictors	Odds Ratio	95% Conf Int		Odds Ratio	95% Conf Int	
Months 2	0.951	0.807	1.122	0.961	0.874	1.057
Months 3	1.023	0.901	1.162	0.901	0.808	1.005
Race/Ethnicity (White)						
Black	2.765	0.628	12.170	0.338	0.109	1.051
Hispanic	1.310	0.330	5.193	0.261*	0.077	0.890
Other	4.074	0.549	30.250	0.292	0.040	2.155
US Citizen	2.297	0.773	6.825	2.074	0.679	6.340
Kids	1.291	0.877	1.901	0.804*	0.655	0.987
Age	1.072*	1.014	1.133	1.015	0.975	1.056
Income	1.263	0.835	1.911	1.486*	1.058	2.087
City (Boston)						
Chicago	1.324	0.434	4.042	1.230	0.554	2.733
San Antonio	2.057	0.848	4.993	2.064	0.975	4.372
Education (No Degree)						
HS Degree/GED	4.341**	1.605	11.737	2.441*	1.047	5.690
College	4.430*	1.026	19.120	4.333**	1.503	12.490
Health (Excellent/Very Good)						
Good	1.081	0.430	2.718	0.730	0.380	1.403
Fair/Poor	1.500	0.539	4.179	1.102	0.432	2.811
Health Problem	0.429	0.101	1.828	0.440	0.079	2.459
Health Need	0.490	0.167	1.439	0.274**	0.123	0.611
Employment Trajectory (Continuous Unemployed)						
Became Unemployed	1.506	0.233	9.714	0.617	0.150	2.539
Kept or Got PT Work	2.802	0.418	18.785	2.161	0.637	7.323
Continuous FT Employed	18.074**	2.531	129.047	14.683***	4.122	52.302
Moved into FT Work	23.492**	3.190	173.025	3.562*	1.203	10.545
Welfare Trajectory (Continuously Off Welfare)						
Moved Off Welfare	0.192*	0.052	0.712	0.859	0.401	1.840
Continuously On Welfare				0.057*	0.006	0.526
Moved On Welfare	0.259	0.058	1.167	0.532	0.154	1.837
Marital Trajectory (Continuously Single)						
Became Single	0.574	0.181	1.821	1.124	0.510	2.479
Started/Stayed Cohabiting	1.752	0.265	11.583	0.854	0.293	2.487
Continuously Married	3.656	0.849	15.750	2.228	0.678	7.319
Moved into Marriage	1.420	0.385	5.231	1.426	0.538	3.781
Continuously Separated	4.357	0.536	35.409	1.213	0.369	3.993
Moved into Separation	0.903	0.315	2.591	1.656	0.717	3.827
N	427			1205		
Log-likelihood	-165.175			-382.613		
Chi^2	87.873			133.648		
Pseudo-R^2	0.430			0.326		

Note: Reference categories in parentheses; *Significant at $p < .05$; ** $p < .01$; *** $p < .001$

Work

Consistent with hypothesis H2a, I find that trajectories leading to full-time employment had more significant effects for near-poor women's access to health insurance than poor women. The finding in Model 31 that moving into full-time work by Wave 3 reduces women's odds of being uninsured appears to be specific to near-poor women; compared to women who were continuously unemployed across all three waves, near-poor women who moved into full-time work by Wave 3 were significantly less likely to be uninsured (see Model 36; 0.208, $p < .05$). The fact that a similar effect was not observed for those who were continuously employed may suggest that women seeking employment may only select work that provides health insurance.

More consistent results were observed for poor and near-poor women in the public and private health insurance models. For example, compared to women who were continuously unemployed across all three waves, both poor (see Model 39; 0.204, $p < .01$) and near-poor women (see Model 38; 0.075, $p < .01$) who were continuously employed full-time were significantly less likely to have public health insurance at Wave 3. The size of the effects varied somewhat though. Perhaps unsurprising, yet consistent with hypothesis H2a, near-poor women who were continuously employed full-time were 92.5 percent less likely to have public health insurance whereas poor women who were continuously employed full-time were only 79.6 percent less likely to have public health insurance as at Wave 3 (see Table 6.5). Similarly, compared to women who were continuously unemployed, both poor and near-poor women who were continuously employed full-time or moved into full-time work were significantly more likely to have private or employment based health insurance at Wave 3 (see Table 6.6). Nevertheless, consistent with hypothesis H2a, near-poor women were much more likely to access these benefits than their poorer peers. For example, near-poor women moving into full-

time employment were 23 times more likely to have private/employer based insurance (see Model 40; 23.492, $p < .01$) whereas poor women who moved into full-time work were only three times more likely to have private/employer based insurance than those who were continuously unemployed (see Model 41; 3.562, $p < .05$). Differences in the effects for poor and near-poor women illustrates how each group may differentially utilize alternative strategies to secure health insurance benefits; whereas near-poor women must rely on greater access to private benefits, poor women are more likely to have access to public health insurance benefits.

Welfare

The findings in part 1 of this analysis that all welfare trajectories are associated with reduced odds of being uninsured (see Model 31) and increased chances of having public health insurance (see Model 33) appear to be specific to poor women. Consistent with hypothesis H2b, I find that fragmented welfare trajectories may not have as large of an impact on poor women as near-poor women. Compared to women who were continuously off welfare across all three waves, poor women with both fragmented and continuous welfare trajectories were all less likely to be uninsured (see Model 37) and more likely to have public health insurance at Wave 3 (see Model 39). Similar effects were observed for near-poor women, but only those who moved onto welfare by Wave 3, while no significant effects were observed for near-poor women who moved off of welfare by Wave 3.[8]

Once again though, variations between categories of women provide important information about variation in the size of the risks various groups of women face. For example, as Model 37 shows, while poor women who moved off of welfare were 56 percent less likely to be uninsured at Wave 3 compared to poor women who were continuously off welfare (0.436, $p <$

[8] Estimates were not produced for near-poor women continuously on welfare because only a small number of near-poor women fell into this category.

.01), poor women who moved on to welfare were over 89 percent less likely to be uninsured at Wave 3 (0.106, $p < .001$). Similarly, comparisons between poor and near-poor women show that poor women who moved onto welfare were nearly 12 times more likely to have public health insurance compared to women who were continuously off welfare (11.844, $p < .001$) while near-poor women who moved on to welfare were only 5 times more likely to have public health insurance at Wave 3 (see Table 6.5; 5.282, $p < .01$).

Another difference was observed between poor and near-poor women's access to private or employer-based health insurance. As might be expected, compared to women continuously off welfare, poor women who were continuously on welfare were significantly less likely to have private or employment based health insurance (see Model 41; 0.057, $p < .05$), while near-poor women who moved off of welfare were significantly less likely to have private or employment based health insurance (see Model 40; 0.192, $p < .05$). The lack of a corresponding increase in near-poor women moving off of welfare's access to public health insurance (see Model 38) once again reveals a hierarchy of risk, with poor women with stable access to welfare at least risk of being uninsured and most likely to have access to public health insurance compared to near-poor women with unstable access to welfare benefits.

Family

Contrary to hypothesis H2c, few effects were observed for marital trajectories on women's access to health insurance. In fact, no significant results were observed for any of the relationship trajectories on women's risk of being uninsured (see Table 6.4) or their access to private/employer based health insurance (see Table 6.6). Perhaps surprisingly, although a significant effect for the continuously married was observed in the public health insurance Model 33, a similar effect was not observed in the public health insurance models separated by poverty

status (see Table 6.5). Instead, Model 38 shows that compared to the continuously single, near-poor women who started or stayed cohabiting across all three waves were significantly less likely to have public health insurance at Wave 3 (0.147, $p < .01$). Consistent with hypothesis H2c, this finding does provide some evidence that resource pooling through cohabitation may have particularly negative consequences for near-poor women in reducing their access to public health insurance options. Nevertheless, the lack of a similar finding for the stably married may indicate that some other effect is operating here.

Research Question 3

Given the effects of welfare, work, and family trajectories on low-income women's health insurance access, do health insurance trajectories play a role is shaping low-income women's economic status over time?

Discontinuities in low-income women's work, welfare, and family trajectories may not only put them at greater risk of having health insurance instability, but may also make them more vulnerable to economic insecurity over time. In addition to the economic costs of discontinuous welfare, work, and family trajectories, unstable health insurance trajectories may also play a role in shaping women's economic outcomes over time. In this section of the analysis I expect to find that health insurance trajectories leading to the loss of insurance will result in greater odds of moving into poverty at Wave 3 (H3a). Because of strict eligibility guidelines, we might also expect to find that stable public insurance trajectories, instead of boosting women's economic progress, may actually represent women's sustained poverty over time (H3b). Finally, I also expect to find that trajectories which represent both stable access to and movement into private

or employment based insurance will support women's economic progress over time by reducing their odds of moving into poverty at Wave 3 (H3c).

Table 6.7 displays the results of the logistic regression analyses for Models 42 and 43, which test how including measures of welfare, work, family, and health insurance trajectories helps us understand changes in women's poverty status over time. The dependent variable in these models measures whether a women experienced a change in poverty status over time or not (0=no change in poverty status, 1=experienced a change in poverty status). Separate analyses are run for women who were not poor at T1 (Model 40) and for those that were poor at T1 (Model 41). Thus, for example, Model 42 tests the effects of welfare, work, family, and health trajectories on the odds of women's movement *into* poverty at Wave 3, whereas Model 43 tests the effects of the same factors on women's movement *out* of poverty at Wave 3. All independent variables included in these models are measured at Wave 3; the trajectory variables measure changes in Wave 1 statuses by Wave 3. The table provides the odds ratios and 95 percent confidence intervals for each model. The reference categories for dummy variables with more than two response categories are indicated in parentheses. Odds ratios and level of significance are also provided in parentheses in the text where appropriate.

The pseudo- R^2 values of Models 42 and 43 suggest that the trajectory model explains more of the variance in women's movement into poverty than their movement out of poverty over time; while Model 42 explains over 30 percent of the variance in women's movement into poverty, Model 43 only explains just over 16 percent of the variance in women's movement out of poverty by Wave 3. This difference in explanatory power may also be related to the difference in sample size for each model as there were significantly fewer women who were not in poverty at Wave 1 than there were women who were in poverty at that time. In addition, it is important to

note that more women moved out of poverty than moved into poverty by Wave 3. In the analysis below I focus my discussion on the effects of the welfare, work, family, and health insurance trajectories on changes in women's poverty status at Wave 3.

As described below, I find some variations in the effects of various welfare, work, family and health insurance trajectories on women's movement into and out over poverty over time. For example, as Model 42 shows, while continuous full-time employment and marriage help reduce the risk of low-income women moving into poverty by Wave 3, moving off of welfare and moving into public health insurance significantly increase women's risk of moving into poverty by Wave 3. In Model 43 we see that other trajectories play a more significant role in affecting women's movement out of poverty over time. For example, although, as might be expected, continuous full-time employment increases women's odds of moving out of poverty over time, both part-time work and new full-time employment trajectories also improve women's odds of moving out of poverty over time. Consistent with this finding, gaining private or employer health insurance is also associated with greater odds of moving out of poverty over time. Finally, I also find that in addition to marriage, cohabitation also provides positive benefits for low-income women by increasing their odds of moving out of poverty over time.

Table 6.7 Logistic Regression Results Comparing Models on Poverty Change by Wave 3 (0=No Change, 1=Change in Poverty Status)

	Near-poor W1 Model 42 (Movement Into Poverty T2)			Poor W1 Model 43 (Movement Out of Poverty T2)		
Wave 3 Predictors	Odds Ratio	95% Conf Interval		Odds Ratio	95% Conf Interval	
Months 2	0.805**	0.692	0.936	0.979	0.907	1.056
Months 3	1.023	0.908	1.152	1.019	0.952	1.090
Race/Ethnicity (White)						
Black	0.371	0.089	1.540	0.980	0.357	2.688
Hispanic	0.269	0.065	1.112	1.413	0.524	3.809
Other	0.783	0.100	6.120	0.528	0.104	2.667
US Citizen	0.743	0.208	2.653	1.471	0.678	3.193
Kids	1.062	0.740	1.525	0.856*	0.738	0.994
Age	1.010	0.958	1.066	0.995	0.970	1.021
City (Boston)						
Chicago	1.460	0.477	4.475	0.666	0.397	1.115
San Antonio	3.334*	1.172	9.481	0.548	0.294	1.020
Education (No Degree)						
HS Degree/GED	0.828	0.334	2.048	1.839**	1.176	2.876
College	0.299*	0.091	0.981	1.399	0.649	3.013
Health (Excellent/Very Good)						
Good	1.383	0.572	3.344	0.920	0.564	1.500
Fair/Poor	0.927	0.363	2.366	0.753	0.441	1.288
Health Problem	1.174	0.232	5.948	1.187	0.619	2.274
Health Need	2.112	0.726	6.146	1.527	0.846	2.754
Employment Trajectory (Continuous Unemployed)						
Became Unemployed	0.369	0.100	1.356	1.537	0.835	2.827
Kept or Got PT Work	0.919	0.186	4.553	2.097*	1.084	4.060
Continuous FT Employed	0.119**	0.028	0.510	3.504*	1.149	10.690
Moved into FT Work	0.388	0.096	1.571	2.534*	1.205	5.331
Welfare Trajectory (Continuously Off Welfare)						
Moved Off Welfare	3.387*	1.200	9.560	1.053	0.646	1.716
Continuously On Welfare	16.789*	1.106	254.937	1.443	0.636	3.277
Moved On Welfare	4.999	0.480	52.090	0.957	0.416	2.205
Marital Trajectory (Continuously Single)						
Became Single	0.861	0.288	2.576	1.269	0.679	2.374
Started/Stayed Cohabiting	0.550	0.129	2.351	3.254**	1.383	7.657
Continuously Married	0.289*	0.091	0.917	2.845*	1.213	6.676
Moved into Marriage	0.898	0.225	3.586	1.918	0.933	3.945
Continuously Separated	0.614	0.123	3.061	0.685	0.286	1.644
Moved into Separation	0.564	0.170	1.876	1.484	0.814	2.706
Insurance Trajectory (Continuously Uninsured)						
Became Uninsured	3.311	0.793	13.835	1.312	0.538	3.197
Continuous Public HI	5.782	0.939	35.611	0.774	0.305	1.961
Moved into Public HI	9.631*	1.708	54.292	1.404	0.561	3.512
Continuous Priv/Emp HI	2.676	0.622	11.510	3.574	0.861	14.829
Got Private/Employer HI	1.782	0.433	7.332	3.543*	1.222	10.272
N	425			1142		
Log-likelihood	-204.278			-638.171		
Chi^2	85.635			95.014		
Pseudo-R^2	0.304			0.164		

Note: Reference categories in parentheses; *Significant at $p < .05$; ** $p < .01$; *** $p < .001$

Work Trajectories

As might be expected, compared to those who were continuously unemployed across all three waves, those with a continuous full-time employment trajectory were significantly less likely to move into poverty at Wave 3 (see Model 42; 0.119, $p < .01$) and significantly more likely to move out of poverty at Wave 3 (see Model 43; 3.504, $p < .05$). Model 43 also shows that women experiencing new full-time work trajectories were also more likely to move out of poverty over time compared to those who were continuously unemployed (2.534, $p < .05$). Perhaps more surprising is the finding that women experiencing stable or new part-time work trajectories were also more likely to move out of poverty at Wave 3 (see Model 43; 2.097, $p < .05$). Nevertheless, while stable part-time employment may be sufficient to technically elevate low-income women out of poverty over time, Models 31 and 35 of this chapter suggest that the benefits of part-time work do not translate into improved access to private health insurance or reduced risk of being uninsured.

Welfare Trajectories

Although welfare trajectories did not appear to be significant predictors of women's movement out of poverty by Wave 3 (see Model 43) they do appear to have significant effects on women's movement into poverty over time (see Model 42). As might be expected, compared to women who were continuously off welfare over time, women who were continuously on welfare were significantly more likely to move into poverty by Wave 3 (see Model 42; 16.789, $p < .05$). Perhaps more surprising though, compared to women who were continuously off welfare, women who moved off of welfare by Wave 3 were also significantly more likely to move into poverty a Wave 3 (see Model 42; 3.387, $p < .05$). This finding suggests that trajectories leading

to the loss of welfare put women at significant risk of economic insecurity following the loss of benefits.

Family Trajectories

Marriage trajectories also influenced women's odds of moving into and out of poverty over time. Compared to those who were continuously single across all three waves, women who were continuously married were significantly less likely to move into poverty at Wave 3 (see Model 42; 0.289, $p < .05$) and more likely to move out of poverty at Wave 3 (see Model 43; 2.845, $p < .05$). It appears that the benefits of resource pooling through marriage in improving women's economic standing may also be accrued through cohabitation; although new or stable cohabitation did not appear to affect women's odds of moving into poverty over time (see Model 42), new or stable cohabitation trajectories were associated with increasing women's odds of moving out of poverty by Wave 3 (see Model 43; 3.254, $p < .01$). Once again though, as Models 31 and 35 show, the benefits of cohabitation in improving low-income women's economic resources do not translate into improved access to private health insurance or reduced risk of being uninsured at Wave 3.

Insurance Trajectories

Contrary to hypothesis H3b, I did not find evidence that compared to the continuously uninsured women experiencing stable public insurance trajectories were more or less likely to move into or out of poverty over time. Nevertheless, consistent with the hypothesis, I did find that compared to the continuously uninsured women who moved into public health insurance by Wave 3 were significantly more likely to move into poverty by Wave 3 (see Model 42; 9.361, $p < .05$). Also consistent with hypothesis H3c, Model 43 shows that compared to the continuously

uninsured, women who moved into private or employer based health insurance by Wave 3 were significantly more likely to move out of poverty by Wave 3 (see Model 43; 3.543, $p < .05$).

Contrary to hypothesis H3a, I found no evidence to suggest that health insurance trajectories leading to the loss of insurance resulted in greater odds of moving into poverty at Wave 3.[9] As described in previous analyses, the lack of significant findings may be a result of the complex relationship between economic progress and insurance access; while becoming uninsured due to loss of public health insurance benefits may be a result or indicator of economic progress, becoming uninsured due to loss of private/employer health insurance benefits may be a result or indicator of economic decline. Nevertheless, despite the consistency of the findings that movement into public health insurance is associated with movement into poverty over time while movement into private or employer based health insurance is associated with movement out of poverty over time, as described in previous analyses, based on the given models it is difficult to determine if movement into these forms of insurance was part of the cause of changes in women's poverty status, or if these health insurance transitions were merely reflections of changes in women's poverty status over time.

Summary

In this chapter I find evidence that utilizing trajectory measures helps provide a more nuanced understanding of the way low-income women's lives affect their access to health insurance, that certain welfare, work, and family trajectories have greater consequences for low-income women's access to health insurance than others, and that the significance of these factors

[9] This finding was also observed in a separate analysis, not shown, using the continuously private/employer insured as the comparison group. Nevertheless, I did find that compared to those continuously on private/employer health insurance, those continuously on public health insurance were significantly less likely to move out of poverty over time (0.213, $p < .030$).

varies by type of insurance examined. In addition, I find evidence of important similarities and differences between poor and near-poor women in the effects of these trajectories on their access to insurance. Finally, I also find evidence that utilizing welfare, work, family, and insurance trajectories helps to explain some of the variance in low-income women's movement into and out of poverty over time.

Specifically, in regards to my first research question I find that the benefits and risks associated with coupling in regards to women's access to health insurance appear to be restricted to those who are stably married as similar effects are not observed for the newly married or new or continuous cohabiters. Compared to the continuously single, stably married low-income women are significantly less likely to have public health insurance (see Model 32) and more likely to have private or employer-based insurance (see Model 34). Although it may be tempting to assume that those who lose access to public health insurance benefits due to marriage are automatically able to gain access to private health insurance benefits as dependents, there is insufficient evidence to support this conclusion as stable marriage trajectories do not produce significant results in the uninsured Model 31. A lack of significant effects for stable marriage on women's risk of being uninsured may be due to the complex effects of marriage and resource pooling on low-income women's access to insurance; although marriage may decrease some women's odds of being uninsured by allowing them access to private benefits as dependents, it may also simultaneously increase other women's odds of being uninsured by limiting their access to public health insurance benefits.

In contrast, more mixed effects are observed for employment trajectories. For example, although I find evidence that continuous employment trajectories reduce women's access to public health insurance options (see Model 32), I also find that continuous full-time employment

trajectories are associated with increased access to private or employment based insurance (see Model 35). Despite these complimentary findings, they do not necessarily indicate that low-income women with stable employment trajectories are less likely to be uninsured, as Model 31 shows that only women who moved into new full-time work by Wave 3 were significantly less likely to be uninsured. This may be related to the finding that even women who move into new full-time work are more likely to have access to private or employer based insurance than those who are continuously unemployed (see Model 35). Together, these findings may suggest that low-income women are being very selective in deciding which jobs to take, only opting for new full-time work if it provides access to benefits given the risk long-term full-time employment poses on women's access to public health insurance benefits (see Model 32).

I also find some evidence that the delinking of welfare and public health insurance benefits has been somewhat successful in protecting women who are experiencing welfare changes from also losing their public health insurance benefits. As might be expected, both continuous and new access to welfare increased women's odds of being on public insurance (see Model 33) and also reduced their odds of being uninsured (see Model 31). Perhaps surprisingly, even women who experienced trajectories leading to loss of welfare benefits were also less likely to be uninsured (see Model 31) and more likely to have public health insurance (see Model 33) than women who were continuously off welfare. Although this provides some evidence of successful delinking of welfare benefits from public health insurance benefits, considerable differences in the odds of being uninsured and having access to public health insurance *between* women in different welfare trajectories suggests that women who lose access to welfare over time are indeed at greater risk of being uninsured and losing access to public health insurance than women who are stably on welfare over time.

In regards to my second research question I find that some of the effects observed in the first part of this chapter can partially be explained by women's poverty status. For example, the observation that there are few differences between the various effects of welfare trajectories on women's access to public insurance and risk of being uninsured appear to be limited primarily to poor women. Compared to women who were continuously off welfare across all three waves, poor women with both fragmented and continuous welfare trajectories were all less likely to be uninsured (see Model 37) and more likely to have public health insurance at Wave 3 (see Model 39). Some similar effects were observed for near-poor women, but only for those who moved onto welfare by Wave 3. Furthermore, close evaluation reveals notable differences in the size of the effects for poor and near-poor women with poor women moving onto welfare being much less likely to be uninsured and much more likely to have public health insurance than near-poor women moving onto welfare (see Models 36 and 38). In addition, Model 40 shows that near-poor women who moved off of welfare were significantly less likely to have private or employment based health insurance.

The finding in Model 31 that moving into full-time work by Wave 3 reduces women's odds of being uninsured also appears to be specific to near-poor women; compared to women who were continuously unemployed across all three waves, near-poor women who moved into full-time work by Wave 3 were significantly less likely to be uninsured (see Model 36). The fact that a similar effect was not observed for those who were continuously employed may suggest that women seeking employment may only select work that provides health insurance. Where employment trajectories produced consistent results for both poor and near-poor women, differences in the size of the effects show that continuous and new full-time employment trajectories are more consequential for near-poor women's access to public and private benefits

than poor women (see Tables 6.5 and 6.6). Such differences highlight the unique opportunities and risks poor and near-poor women face and illustrate how each group may differentially utilize alternative strategies to secure health insurance benefits; whereas near-poor women must rely on greater access to private benefits, poor women are more likely to have access to public health insurance benefits.

Finally, in regards to my third research question I find some variations in the effects of various welfare, work, family and health insurance trajectories on women's movement into and out over poverty over time. For example, Model 42 shows that several employment trajectories improved women's odds of moving out of poverty over time; part-time work and new full-time work appear to provide similar economic benefits to continuous full-time work in improving women's odds of moving out of poverty. Nevertheless, while stable part-time employment, for example, may be sufficient to technically elevate low-income women out of poverty over time, Models 31 and 35 of this chapter suggest that the benefits of part-time work do not translate into improved access to private health insurance or reduced risk of being uninsured.

Although welfare trajectories did not appear to be significant predictors of women's movement out of poverty by Wave 3 (see Model 43) they do appear to have significant effects on women's movement into poverty over time (see Model 42). For example, compared to women who were continuously off welfare, women who moved off of welfare by Wave 3 were significantly more likely to move into poverty at Wave 3 (see Model 43). This finding suggests that trajectories leading to the loss of welfare put women at significant risk of economic insecurity following the loss of benefits.

Marriage trajectories also influenced women's odds of moving into and out of poverty over time. Compared to those who were continuously single, women who were continuously

married were significantly less likely to move into poverty (see Model 42) and more likely to move out of poverty at Wave 3 (see Model 43). In addition, I find some evidence that the benefits of resource pooling through marriage may also be accrued through cohabitation as new or stable cohabitation trajectories were associated with increasing women's odds of moving out of poverty by Wave 3 (see Model 43). Once again though, as Models 31 and 35 show, the benefits of cohabitation in improving low-income women's economic resources do not translate into improved access to private health insurance or reduced risk of being uninsured at Wave 3.

Finally, although I did find that women who moved into public health insurance by Wave 3 were significantly more likely to move into poverty (see Model 42) and women who moved into private or employer based health insurance were significantly more likely to move out of poverty (see Model 43), as described in previous analyses, it is difficult to determine if movement into these forms of insurance was part of the cause of changes in women's poverty status, or if these health insurance transitions were merely reflections of changes in women's poverty status over time. In addition, the lack of significant findings for trajectories leading to loss of insurance may be a result of the complex relationship between economic progress and insurance access; while becoming uninsured due to loss of public health insurance benefits may indicate economic progress, becoming uninsured due to loss of private/employer health insurance benefits may indicated economic decline. Further work is needed in this area to adequately determine the effects of welfare changes on women's poverty status.

In addition to the effects of various welfare, work, and family trajectories on women's access to insurance and economic progress, I also find evidence of important city differences in the risks of being uninsured and access to private and public forms of health insurance. Consistent across analyses, Hispanic respondents and those living in Chicago and San Antonio

were significantly more likely to be uninsured (see Table 6.1). Similarly, increased income and living in Chicago and San Antonio were also associated with reduced odds of having access to public health insurance (see Table 6.2). Despite the fact that women living in San Antonio were more likely to have private or employer based insurance than women living in Boston (see Table 6.3), women in San Antonio were also the most likely to be uninsured (see Table 6.1), a finding that appears consistent with the state's emphasis on limited state government and market-based solutions to improving health insurance access. The implications and possible explanations of these findings are discussed further in Chapter 7.

CHAPTER SEVEN

DISCUSSION AND CONCLUSIONS

In this dissertation I have tested the effects of several different kinds of longitudinal welfare, work, family, and health insurance measures on women's access to health insurance and economic progress over time in an effort to better understand how the dynamic nature of low-income women's lives affects their access to care and well-being. In Chapter 4, I observe that low-income women's welfare, work, and family statuses at one time point have long-term effects on their health insurance access and poverty status over time. Thus, knowing the work, family, and welfare characteristics of low-income women at one time point can allow us to make predictions about their access to insurance and economic prospects "down the road" and may allow us to implement appropriate interventions.

In Chapter 5, I observe that utilizing measures of welfare, work, and family change across two time points provide us with even more information about low-income women's access to health insurance. The analyses show that certain changes appear more consequential than others, putting low income women at greater risk of being uninsured while other changes appear to increase women's odds of gaining access to other forms of insurance. I also observe that welfare, work, family and insurance changes have differential effects on women's odds of moving into and out of poverty over time. These findings suggest that static measures of women's characteristics, although important, may not tell the whole "story," as experiencing changes in welfare, work, family, and insurance characteristics have independent effects on women's access to insurance and economic progress.

Finally, in Chapter 6, I observe how welfare, work, family, and health insurance trajectories – which measure changes over three time points – also offer improvements over cross-sectional measures by providing a more nuanced picture of how low-income women's long-term welfare, work, and family histories affect their access to various forms of insurance and economic progress over time. These findings corroborate the findings in earlier chapters which suggest that welfare, work, and family factors have long-term consequences for low-income women and that certain changes may put women at more (or less) risk of negative outcomes at later time points.

In addition to these findings, in each chapter I also observe that many of the effects of various welfare, work, and family characteristics are specific to certain categories of low-income women; while some factors appear to be more consequential for poor women, others reveal the unique risks of near-poor women who may struggle economically, yet fail to qualify for public programs. Together, comparisons between poor and near-poor women illustrate the diversity of low-income women's lives and the unique challenges and coping strategies groups of low-income women may rely on in order to meet their health care and economic needs. In addition to group differences, I observe that race/ethnic, citizenship, and geographic characteristics shape the policy contexts in which low-income women must operate as they navigate the welfare, work, family, and health insurance changes they encounter over time.

In this chapter I summarize the major findings across all three data analysis chapters (Table 7.1 provides a summary and comparison of the results across chapters). I also discuss possible explanations for the results and the implications of the findings. Finally, I address the theoretical and policy implications of the findings, the limitations of the analyses presented, and possible directions for future research.

Table 7.1 Summary of Major Findings

	Lagged Effects	Change Models	Trajectory Models
Research Question 1			
Welfare, Work, & Family	Public programs reduce risk of uninsured; Employment increases access to private HI but reduces access to Medicaid; Marriage increases access to private HI but reduces access to Medicaid	New or stable work reduce access to Medicaid, increase access to private HI, but only stable work reduces risk of uninsured; Stable welfare best, lose welfare increases risk of uninsured; Only stable marriage matters	Stable marriage penalty but increase access to private HI; Stable work reduces access to Medicaid, increases access to private HI; Losing welfare puts women at greater risk than those with stable welfare access
Health	Medicaid critical for those with health problems, reduces risk of having unmet health needs	Medicaid critical for those with health problems, reduces risk of having unmet health needs	Medicaid critical for those with health problems, reduces risk of having unmet health needs
Research Question 2			
Poor Women	Race, marriage, and welfare access shape access to Medicaid, risk of uninsured	Better protected against effects of welfare change; Stable marriage penalty	Less affected by welfare disruptions
Near-poor Women	Employment and health factors shape access to private HI and risk of uninsured; More vulnerable to poor health, greater risk of unmet health needs	Stable or new work more important for access to Medicaid; Less protected against effects of welfare transitions; May be more free to leave marriages	New and stable work more important; May only take work if provides benefits
Research Question 3			
Welfare, Work, & Family	Marriage increases odds of moving out of poverty; Welfare increases odds of poverty	New or stable work, stable marriage reduce odds of becoming poor; Lose welfare, increase risk of poverty	PT and new work help women move out of poverty; Losing welfare increase risk of poverty; Resource pooling helps
Insurance	On Medicaid increase risk of poverty	Public HI increase risk of poverty, private reduces risk	Moving into public HI increases risk, moving into private reduces
City Differences			
	IL,TX more likely uninsured, less likely on Medicaid; Poor in TX at greatest risk	IL, TX less likely to move out of poverty; Poor in TX more likely to have private HI but great risk	IL,TX more likely uninsured, less likely on Medicaid; TX more private HI, but at great risk

Family Factors and Change

Existing research shows that women's marital status has direct effects on their access to insurance by providing access to private insurance options as a dependent. Nevertheless, research specific to low-income families provides evidence of a marriage penalty for low-income families who may lose access to public benefits – but be unable to afford private benefits – due to strict eligibility guidelines. The results of my analyses suggest that the effects of marriage on low-income women's access to insurance may not be readily apparent; in Chapters 5 and 6 we see that movement into marriage does not have the same effects on low-income women's access to insurance as stable or long-term marriage does – a finding supported by the results of Chapter 4 where we observe significant lagged effects for marriage over time.

Consistent across the lagged effects, change, and trajectory models, I find that stable or long-term marriage is associated with improved access to private or employer-based health insurance benefits and reduced access to public insurance for low-income women. Although we might be tempted to assume that those who lose access to public health insurance benefits due to marriage are automatically able to gain access to private health insurance benefits as dependents, I find insufficient evidence to support this conclusion as stable marriage trajectories do not significantly reduce low-income women's odds of being uninsured. The lack of effects for stable marriage on low-income women's risk of being uninsured may be due to the complex effects of marriage and resource pooling on low-income women's access to insurance; although marriage may decrease *some* women's odds of being uninsured by allowing them access to private benefits as dependents, it may also simultaneously increase *other* women's odds of being uninsured by limiting their access to public health insurance benefits. Combined with the fact

that men's access to insurance has become more precarious over time, the benefits of marriage in protecting low-income women in particular from being uninsured may be diminished.

Indeed, the benefits and risks associated with coupling in regards to low-income women's access to health insurance appear to be restricted for the most part to those who are stably married as similar effects were not observed for the newly married or new or continuous cohabiters. Where an effect for new or continuous cohabitation was observed (Model 38) provides us with important information about how marriage may disproportionately affect different categories of low-income women. Model 38 shows that compared to the continuously single, near-poor women who started or stayed cohabiting across all three waves were significantly less likely to have public health insurance at Wave 3. This finding provides some evidence that resource pooling through cohabitation has particularly negative consequences for near-poor women, while Model 21 provides similar evidence that long-term marriage has more pronounced effects for poor women in reducing their access to public health insurance options.

Employment Factors and Change

Although we often assume full-time employment will provide access to health insurance benefits, the kinds of work that many low-income women have access to often does not provide affordable benefits, putting them at substantially greater risk of being uninsured than other groups of workers. Across the lagged effects, change, and trajectory models I observe fairly consistent effects for total household income in increasing women's access to private or employer-based insurance while reducing women's access to public health insurance. Similarly, I find evidence that continuous full-time employment trajectories reduce women's access to public health insurance options (see Model 32) while increasing their access to private or

employment based insurance (see Model 35). This appears to produce fairly consistent results across models that stable full-time employment trajectories also reduce low-income women's odds of being uninsured. Perhaps surprising, although less consistent across models, new or temporary access to full-time work and even part-time employment opportunities were also associated with improved access to private or employment-based health insurance benefits (see Model 17). Nevertheless, close examination reveals that stable or long-term full-time employment provides low-income women with the best increase in access to private or employment based benefits. In addition, the benefits of stable full-time employment appear to be most pronounced for near-poor women who may be more likely to rely on the private insurance market due to an inability to qualify for public health insurance options.

Welfare Factors and Change

Close examination of the findings presented in these analysis reveal mixed support for the successful delinking of welfare and Medicaid benefits following 1996 Welfare Reform. Consistent across the lagged effects, change, and trajectory models, low-income women's long-term access to welfare benefits is associated with increased likelihood of having public health insurance and decreased likelihood of having private or employment based health insurance. This appears to produce an overall positive effect in reducing women with stable welfare access's odds of being uninsured. Once again though, close examination is warranted as comparisons between poor and near-poor women consistently suggest that poor women with stable welfare access benefit most from the greatest increase in odds of having access to public health insurance and greatest reduction in odds of being uninsured.

In addition to variations between poor and near-poor women, it is important to note consistent differences in the effects of specific welfare trajectories and change categories on low-income women's access to insurance; although women with discontinuous welfare histories also benefit from improved access to public health insurance, the best outcomes are observed among those with stable welfare trajectories who appear to be the least likely to be uninsured and most likely to have access to public health insurance benefits. Although we may be tempted to assume these results prove a successful delinking of public health insurance and welfare benefits, close examination reveals the importance of considering the comparison group when interpreting analyses. In the context of low-income women's welfare changes and trajectories, the comparison group really matters for adequately understanding their access to health insurance; while women with discontinuous welfare trajectories may be doing better than their peers who lack access to welfare over time, they do not fare as well as their peers who sustain stable access to welfare over time. In addition, comparisons between poor and near-poor women also suggest that poor women benefit most from the benefits of access to welfare whereas near-poor women experience greater variability in the effects of discontinuous welfare trajectories on their access to public health insurance and risk of being uninsured.

The Effects of Health Factors

Although general health can affect one's ability to work and secure health insurance benefits in the private and public markets, surprisingly I found few consistent effects for measures of general health on women's access to insurance and economic progress over time. Nevertheless, other health measures did produce significant results. Consistent across the lagged effects, change, and trajectory models was the finding that women who experienced health

problems that affected their ability to work were significantly more likely to be on public health insurance and less likely to be uninsured than women who did not have health problems. Similarly, women who had health needs that went unmet due to cost were significantly more likely to be uninsured and less likely to have either public health insurance or private or employer based health insurance. Some differences between poor and near-poor women in the significance of health measures suggest that near-poor women are more negatively affected by health problems that affect their ability to work (see Model 8), and in these cases public programs become an important source of health insurance for these women (see Model 6). These results provide compelling evidence that public health insurance programs play a vital role in both providing insurance to low-income women with health problems and protecting them from having unmet health needs. Low-income women without insurance, on the other hand, and in particular near-poor women, are at great risk of being unable to meet their healthcare needs due to the cost of care (see Model 4).

Variations between Low-income Women

It may be tempting to treat low-income women as a unified homogenous category for analysis, yet we know that the degree of women's economic vulnerability has a profound effect on the kinds of programs women have access to. Although both poor and near-poor women may experience similar vulnerabilities, I find evidence that there are in fact important differences between low-income women that put some at greater (or less) risk of inadequate access to insurance. My findings reveal a hierarchy of risk, with poor women with stable access to welfare at least risk of being uninsured and most likely to have access to public health insurance compared to near-poor women with unstable access to welfare benefits (see Tables 6.4-6.6). The

findings also suggest a more complicated relationship between employment and health insurance access for near-poor women which makes them more vulnerable to welfare, work, and family changes. Although near-poor women who have health problems that affect their ability to work may be able to utilize public health insurance options to protect them against being uninsured, near-poor women who have poor health but are unable to qualify for public health insurance options may be compelled to maintain private/employment based benefits since they experience a much greater reduction in access to public health insurance following finding full-time work (see Model 22). Such differences highlight the unique opportunities and risks poor and near-poor women face and illustrate how each group may differentially utilize alternative strategies to secure health insurance benefits; whereas near-poor women must rely on greater access to private benefits, poor women are more likely to have access to public health insurance benefits. Because low-income women's economic status is rarely stagnant, they may find themselves utilizing both sets of strategies across the life course.

Low-income Women's Economic Progress

The economic vulnerability created by welfare, work, and family changes has direct consequences for women's economic progress over time. I find that including measures of welfare, work, family, and health insurance access does a better job of explaining women's movement into poverty than out of poverty. For example, although welfare changes appeared to have little effect on women's access to various forms of insurance, I find evidence that moving off welfare puts women at greater risk of moving into poverty over time (see Models 28 and 42). In contrast, the lack of effect for welfare transitions on women's movement out of poverty over time suggest that exiting welfare may not necessarily indicate women's economic progress over

time. As might be expected, access to greater resources plays an important role in elevating low-income women out of poverty over time. In fact, I find that even part-time and new full-time work trajectories were associated with improved economic outcomes for women over time (see Model 43). Despite the lack of consistent effects for cohabitation on women's access to insurance, my findings also suggest that resource pooling through both marriage or cohabitation may improve women's economic progress by increasing women's odds of moving out of poverty over time (see Models 11 and 43).

In addition to demonstrating the effects of welfare, work, and family transitions on women's economic progress, I hoped to also be able to show that women's insurance transitions affect their economic well-being over time. Nevertheless, I found that including measures of health insurance access and change only offered slight improvements in my ability to explain changes in women's poverty status over time. In addition, while I do find statistically significant relationships between some types of insurance transitions and women's poverty status – for example, getting private insurance benefits increases women's odds of moving out of poverty (see Models 29 and 43) while getting public insurance benefits increases women's odds of moving into poverty over time (see Models 26 and 42) – these results may not actually reflect a causal relationship between women's insurance transitions and poverty transitions. Instead, women's insurance transitions may serve as indicators of women's poverty status; women in poverty are simply more likely to have public health insurance and while women not in poverty are more likely to have private health insurance.

Policy Contexts

My findings also consistently show that women in Chicago and San Antonio are more likely to be uninsured and less likely to have public health insurance than those living in Boston. In addition, the effects of city of residence are most notable for women living in San Antonio – especially the poor and Hispanics – who appear to face greater risks in terms of lack of access to health insurance than other groups of women. The state's emphasis on market solutions to providing health care are also supported by the finding that poor women living in San Antonio were significantly more likely to have private or employer-based insurance than poor women living in Boston (see Models 23 and 35). Such findings illustrate the importance of state-specific policy contexts for understanding low-income women's access to various forms of health insurance and women's health outcomes (see also Zimmerman and Legerski 2010). These findings also illustrate the importance of separately examining different forms of insurance access; while Texas' approach to limiting state programs and encouraging market solutions may make women there more likely to have private insurance, such an approach also limits women's access to public programs, leaving them at greater risk of being uninsured. My findings also suggest that even more moderate policy approaches to extending health insurance to low-income women, like those supported in Illinois, restrict low-income women's access to public programs and result in greater risk of being uninsured than more state-centered policy solutions like those embraced in Massachusetts.

Implications

These results have implications for scholarly theory and well as public policy. In terms of implications for scholarly theory, my findings support a welfare regime perspective which emphasizes the need to examine interactions between state, market, and family factors. The

complex relationship between health insurance access and marriage, for example, illustrates the need to consider the connections between institutions; while the relationship between marriage and the state penalizes low-income women, the relationship between marriage and the market rewards women with access to benefits as dependents. Nevertheless, a critical link is missing here; as demonstrated by the findings above, the lack of an adequate market-state link in regards to health insurance provision creates notable gaps in coverage for low-income women as they experience various welfare, work, and family changes. This research highlights the need to consider these relationships as we develop our research agendas and use our findings to develop better public policy.

Although much has been said by feminist scholars about the effects of welfare reform on the welfare-reliant woman's access to health insurance, and more attention is currently being focused on the plight of the wage-reliant woman as the economy changes and women become more responsible for being the primary breadwinners (and thus benefit providers) for their families, much less has been said about the family-reliant woman and her changing access to health insurance. My findings clearly illustrate that stable, long-term marriage plays a role in shaping women's access to both public and private forms of insurance. Nevertheless, as described above, the relationship between the family, state, and market has produced contradictory effects for the family-reliant woman. Ineffective and contradictory state policy – which ironically promotes marriage among the low-income while penalizing married women by limiting their access to public health insurance options – illustrates the lack of attention to the complexities of women's lives and the vulnerabilities that marriage may create for low-income women.

These findings also have important implications for public policy. The health care reforms scheduled to be implemented as early as June 2010 promise to extend health care coverage to 32 million Americans while cutting the federal deficit by $124 billion (Kaiser Family Foundation 2010b, 2010c). Some of the reforms included will benefit women generally, while others aim to help low-income individuals in particular. For example, currently 40 states allow gender based premium rating in the individual health insurance market, which often results in women paying higher premiums for the same coverage as men (Codispoti, Courtot, and Swedish 2008). Although technically illegal, gender rating has also been incorporated into the group health insurance market by insurance companies who charge higher premiums in industries dominated by women (Courtot and Kaye 2009). The new health care reform law prohibits gender rating by only allowing premium rating based on age (with some limitations), family size, tobacco use, and geographic residence (Kaiser Family Foundation 2010b).

Health care reform will also benefit women by prohibiting denial of coverage based on "pre-existing medical conditions." Perhaps surprising, in eight states there are no regulations prohibiting insurance companies from classifying a woman's history of domestic violence as a pre-existing condition for which she can be denied health insurance coverage (Courtot and Kaye 2009). This is particularly consequential during a recession, when domestic violence may be more prevalent due to economic strain. In addition, in 45 states there are no regulations prohibiting insurance companies from classifying previous Cesarean-sections as a pre-existing medical condition (Courtot and Kaye 2009). This is also particularly consequential for women in light of recent estimates showing nearly one-third of all US births are via C-section (Menacker and Hamilton 2010). The new reform law also benefits women by requiring that insurance plans

provide a minimum standard of comprehensive care, including maternity, mental health, and preventative care services such as mammograms (National Women's Law Center 2010).

The health care reform law also includes several provisions that will benefit low-income families. For example, Medicaid eligibility will be expanded to include individuals who in the past may have been disqualified from participation by eliminating the categorical requirements for eligibility and expanding the income threshold to 133 percent of the Federal Poverty Level (Kaiser Family Foundation 2010b). Requirements for employers to provide health insurance may also benefit low-income women who are employed in companies with 50 or more employees, but may be less beneficial for those employed less than full-time and/or in small companies. Nevertheless, establishment of insurance exchanges and non-profit co-ops, as well as availability of premium and cost-sharing subsidies for families with incomes up to 400 percent of the FPL promise to help reduce gaps in coverage for low-income women (Kaiser Family Foundation 2010b; Collins et al. 2008b; Holahan, Cook, and Dubay 2007). Further expanding health insurance options for low-income women, the reform law also allows states to create a health insurance plan just for uninsured individuals with incomes below 200 percent of the FPL (Kaiser Family Foundation 2010b). In addition, the law includes incentives for states to develop "Community-based Collaborative Care Network Programs" to support, coordinate, and integrate services for low-income uninsured and underinsured populations (Kaiser Family Foundation 2010b:2).

Despite the potential benefits of health care reform for women generally and low-income families in particular, by building on the existing health insurance system the reforms fail to challenge the two-tired structure of private/employer-based plans and public health insurance benefits which means gaps in coverage will remain and millions of Americans will continue to

find themselves un- or under-insured (Burman et al. 2008:56). Although there was insufficient support for a truly universal system of healthcare financing and provision in Washington during the health care reform debates of 2009-2010, it is undeniable that federal oversight is critical to make access more equitable across state borders. As illustrated in this dissertation, "state autonomy" has put some women at elevated risk of being uninsured simply based on where they live, and states should be accountable for failing to meet the needs of women.

Limitations

The results of the analyses presented here are limited to low-income women living in low-income neighborhoods in Boston, Chicago, and San Antonio. In addition, the small sample sizes utilized in the Chapter 6 trajectory models, especially in parts 2 and 3 of the analysis which requires separation by poverty status at Wave 1, may limit the explanatory power of Models 36, 38, and 40, which test the effects of various factors on near-poor women's access to health insurance. A larger proportion of the sample was poor at Wave 1 than not poor. In addition, as time went on, more women moved out of poverty than moved into poverty. Although the sample sizes of all models meet common recommendations for minimum sample size based on the number of independent variables (see Long 1997:54), the small number of women who were not poor at Wave 1 and who moved into poverty by Wave 3 warrants some caution in the interpretation and extrapolation of the findings.

The Chapter 5 change measures and Chapter 6 trajectory measures were created using reports of women's welfare, work, family, health, and poverty statues at each wave. Despite the utility of using measures of change to understand women's access to various forms of insurance and poverty status over time (as illustrated in the analyses), because the measures created do not

include changes between waves they ultimately represent conservative estimates of change. It is highly possible that at least some women experienced even greater numbers of changes between waves than the statistics presented in these analyses reveal. Although it would be ideal to construct measures that take into consideration the full extent of changes these women experienced over time, this level of detailed data was simply not available for all variables at all waves.

The statistical analyses presented in Chapters 4, 5, and 6 all utilize data that were imputed using a single imputation method for missing values on four key demographic variables: marital status, citizenship, education, and income. Although it is generally agreed that single imputation methods are superior to mean substitution or listwise deletion of missing values (Acock 2005; Enders 2006; Schafer and Graham 2002), there is more debate over whether a single imputation method is as adequate as a multiple imputation approach which pools the results of several imputations to produce estimates with unbiased standard errors. Despite the statistical benefits of using a multiple imputation method, many researchers suggest that the amount of time and computational power it takes to run multiple imputations and pool the results warrants use of a single imputation method for setting up and testing preliminary analyses (Acock 2005). Although I plan to use multiple imputation for missing values as I prepare the results of these analyses for publication, to facilitate completion of the dissertation I have chosen to use a single imputation method to produce the results presented here.

Directions for Future Research

Although there are many consistencies in the models described above regarding the effects of various welfare, work, and family changes on women's access to health insurance and

economic progress, a thorough qualitative study of how women make work, family, and welfare decisions based on their needs for health insurance would help to illuminate the findings and identify the causal mechanisms at play. Such a qualitative investigation would not only give low-income women voice in expressing the challenges they encounter as they negotiate their relationship between the state, market, and family, but it would also allow scholars to develop better explanatory models and policy makers to devise better public policy solutions to the barriers low-income women face in securing adequate health insurance over the life course.

In addition, although the results of the analyses predicting changes in women's poverty status presented here are useful (particularly in Chapter 6, part 3) the small amount of total variance explained by the models suggests that there are other important characteristics that must be considered and measured and in order to better explain why some low-income women are able to make economic progress over time while others are not able to. The results of previous research and my own analyses suggest that access to health insurance may be an important part of this explanation. Nevertheless, the measures used in the analyses presented here appear to be limited in their overall explanatory power. In future analyses I would like to develop better models for predicting low-income women's economic progress over time. Such a task will require identifying and measuring some of the causal mechanisms responsible for the relationship between both individual and household health, insurance access, and economic well-being.

Understanding the factors that both inhibit and foster low-income women's economic progress over time may have important public policy implications, but it would also be worthwhile to examine the effects of these factors on women's health status over time. Despite contemporary efforts to curtail low-income women's access to social supports, evidence that

welfare, work, family, and health insurance changes affect women's health outcomes may provide compelling evidence for expanding women's long-term access to stable social programs and forms of health insurance.

Exploring the nuances of specific state policy characteristics on low-income women's access to insurance is another area of research that I would like to pursue further in future research. In particular, I would like to examine the effects of state-level policy characteristics, such as specific policy requirements and program sanctions, on women's outcomes across states over time. The states are often described as "laboratories of democracy" in that they allow us to observe the outcomes of state-level experimentation in social policy and program development. What were the specific policy characteristics of Massachusetts, Illinois, and Texas that created such significant variation in women's access to various forms of insurance and economic well-being over time? The benefit of such an analysis lies in the potential to develop effective public policies at both the state and federal levels that will improve women's access to various forms of health insurance and assist in their well-being and independence from exploitive work, family, and state relationships.

As feminist scholars suggest, and other analyses have shown (see Angel, Frias, and Hill 2005), the demographic characteristics of states play an important role in shaping the policy contexts and health outcomes of a region. Although I did not conduct a focused race analysis in this dissertation, race is a fundamental component of the structure and meaning of health care policy and access in the U.S. (see Quadagno 2005). Thus, racial differences in the effects of welfare, work, and family changes and the racialized nature of specific state policies ought to be considered further in future analyses. How is race introduced into the eligibility requirements of

public and private health insurance programs? How does gender and race based economic discrimination affect women's access to insurance?

Finally, given the passage of federal health care reform it will be imperative to monitor the effects of various social policies on women's health and access to care over the next decade. How will mandating health insurance coverage, expanding Medicaid eligibility, creating high risk pools, and regulating the private health insurance market affect women's access to health insurance and care? Despite promises to expand coverage to millions of Americans, who will remain uninsured? Will the needs of low-income women be met under such reforms? What new forms of vulnerability might be created? As specific reforms are implemented it will be vital to track the effects of each policy on women's health and access to care in order to inform future policy decisions.

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